Comagine Health

External Quality Review (EQR)

Annual Technical Report

MO HealthNet

December 2024

Review Period 2023

Presented by:

Comagine Health

Seattle, WA

comagine.org

Comagine Health

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MoHealthNet

As Missouri's Medicaid external quality review organization (EQRO), ***Comagine Health*** *provides external quality review (EQR) and supports quality improvement for Medicaid beneficiaries of Missouri HealthNet (MO HealthNet) managed care programs.*

Comagine Health prepared this report under contract with Missouri Department of Social Services MO HealthNet Division to conduct EQR and quality improvement activities to meet Code of Federal Regulation (CFR) – 42 CFR §462 and 42 CFR §438, Managed Care, Subpart E, External Quality Review.

Comagine Health is a national, nonprofit health care consulting firm. Comagine Health works collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvement in the health care system. Comagine Health is a seasoned EQRO contractor with more than 25 years of experience in evaluation and review activities, including experience in reviewing managed care entities against the Centers for Medicare & Medicaid (CMS) EQR Protocols, CFRs and state compliance with contracts requirements. For more information, visit us online at www.Comagine.org.

MetaStar *is based in Madison, Wisconsin, and has been a leader in health care quality improvement, independent quality review services, and medical information management for more than 50 years, and represents Wisconsin in the Superior Health Quality Alliance, under the CMS Quality Improvement Organization Program. MetaStar is an EQRO contractor for more than 50 years with experience in both mandatory and optional activities outlined in the CMS EQR protocols. For more information, visit www.metastar.com.*

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Acronym List

Table 1. Acronyms Used Frequently in this Report.

Acronym	Definition
AEG	Adult Expansion Group
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CEAC	Counties with Extreme Access Considerations
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CM	Care Management
CMS	Centers for Medicare & Medicaid
CY	Calendar Year
DM	Disease Management
DSS	Department of Social Services
EQR	External Quality Review
EQRO	External Quality Review Organization
HB	Healthy Blue
HEDIS®[1]	Healthcare Effectiveness Data and Information Set
HSH	Home State Health
ISCA	Information Systems Capabilities Assessment
MCP	Managed Care Plan
MHD	MO HealthNet
NAV	Network Adequacy Validation
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PIP	Performance Improvement Project
PMV	Performance Measure Validation
QAPI	Quality Assurance and Performance Improvement
QIS	Quality Improvement Strategy
SMHK	Show Me Healthy Kids
UHC	UnitedHealthcare Community Plan of Missouri

[1] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Executive Summary

Purpose and Overview of Report

Comagine Health, under contract with MO HealthNet (MHD), serves as the external quality review organization (EQRO) for the state of Missouri to independently analyze and evaluate the quality, timeliness and access to health care services provided by managed care plans (MCPs) to Medicaid beneficiaries.

EQR activities, outlined in 42 CFR §438.358, include mandatory and optional tasks designed to:

- Enhance states' oversight and management of contracted MCPs.
- Assist MCPs in enhancing their performance in quality, timeliness, and access to care.

This report summarizes the findings from the 2024 calendar year (CY2024) EQR activities, covering the review period from January 1, 2023, to December 31, 2023, as outlined below, including data aggregation and analysis. No MCPs in Missouri are exempt from the EQR.

- Validation of Performance Improvement Projects
- Validation of Performance Measures
- Review of Compliance with Medicaid and CHIP Managed Care Regulations
- Validation of Network Adequacy
- Care Management Review

Missouri Medicaid Program Overview

The mission of the Missouri Department of Social Services (DSS) is to "Empower Missourians to live safe, healthy, and productive lives." DSS is responsible for administering the MHD program, formerly known as the Missouri Medicaid Program.

MHD's purpose, through DSS, is to purchase and monitor health care services for low income and vulnerable citizens of the state of Missouri. MHD assures quality health care through development of service delivery systems, standards setting and enforcement and education of MHD providers and participants.

The DSS MHD Managed Care Program delivers services to individuals through a 1915(b) Waiver that allows the managed care system to provide Medicaid services to Section 1931 children and related poverty-level populations, Section 1931 adults and related poverty populations, including pregnant women, Children's Health Insurance Program (CHIP) children and foster care children.

Missouri's CHIP was a Medicaid expansion implemented on September 1, 1998, through a waiver under Section 1115 of the Social Security Act. Missouri's CHIP State Child Health Plan uses funds provided under Title XXI to both expand eligibility under Missouri's State Medicaid Plan and to obtain coverage that meets the requirements for a separate child health program.

A constitutional amendment was passed in August 2020 requiring the state to offer services to adults ages 19-64 with income up to 138 percent of the federal poverty level. These adults began receiving services through the managed care system October 1, 2021, under Section 1932(a), known as the Adult Expansion Group (AEG).

Effective July 1, 2022, the MHD Managed Care Program awarded a Specialty Plan, known as Show Me Healthy Kids (SMHK), to provide integrated care for State Care and Custody children. SMHK was established to provide a trauma-informed comprehensive and integrated behavioral health/physical health delivery system allowing these children and youth to grow into healthy adults and live full and satisfying lives.

In Missouri, Medicaid beneficiaries are covered by four MCPs. As of December 2023, there were 1,116,904 individuals enrolled in MHD, Managed Care.

Health Plan Background

Healthy Blue (HB)

HB is a Medicaid product offered by Missouri Care, Inc., an MHD MCP. Missouri Care, Inc. oversees the administration of HB in Missouri and collaboratively manages services in the Kansas City region with Blue Cross and Blue Shield of Kansas City. Both Missouri Care, Inc., and Blue Cross and Blue Shield of Kansas City are independent licensees of the Blue Cross and Blue Shield Association.

As of December 2023, HB served 392,239 Medicaid enrollees. Their mission is to provide members with the necessary coverage while ensuring they understand how to use and maintain their benefits. HB maintains consistent accreditation from the National Committee for Quality Assurance (NCQA) and achieved Health Equity Plus accreditation in 2023.

Home State Health (HSH) and Show Me Healthy Kids (SMHK)

HSH, an MHD MCP, and a wholly owned subsidiary of Centene Corporation, operates with a vision to transform the health of the community, one person at a time. HSH delivers coordinated, holistic, integrated and high-quality services to Medicaid beneficiaries across the state of Missouri.

SMHK is a specialty plan managed by HSH. SMHK's vision is to transform the health of the community one person at a time. Starting in July 2022, SMHK began delivering coordinated, holistic, integrated and high-quality services to Missouri children in care and custody.

As of December 2023, HSH served 346,041 Medicaid enrollees and SMHK served 49,252 Medicaid enrollees. HSH holds an NCQA accreditation.

UnitedHealthcare Community Plan of Missouri (UHC)

UHC's Community Plan of Missouri, an MHD MCP, vision is to empower members to reach their full health potential through a sustainable care ecosystem that delivers equitable care whenever and wherever they need it. As of December 2023, UHC served 329,372 Medicaid enrollees.

UHC has achieved NCQA Health Plan and Health Equity accreditations, in addition to obtaining National Credentialing and Utilization Management accreditation through NCQA.

Missouri Managed Care Program and Initiatives

MHD is the Medicaid managed care program for the state of Missouri, providing comprehensive health coverage to eligible low-income individuals and families. The program aims to ensure access to quality health care services, promote health outcomes and support the well-being of its beneficiaries.

MHD is committed to ensuring appropriate access to care for its managed care population. This includes monitoring appointment standards and network adequacy, guaranteeing that beneficiaries can receive timely and necessary care from a sufficient network of providers. By expanding access to care, MHD helps reduce disparities and promotes health equity for vulnerable populations.

MHD promotes the use of preventative services to empower individuals to take control of their health. By emphasizing preventative care, MHD helps beneficiaries lead healthier lives, reducing the need for costly medical interventions.

MHD is particularly focused on improving maternal health outcomes, recognizing the importance of high-quality prenatal, delivery and postpartum care. Through targeted initiatives and partnerships with the MCPs, MHD works to reduce maternal mortality and morbidity, promote healthy birth outcomes, and support the well-being of new mothers and their families.

In addition, MHD strives to ensure cost-effective utilization of services, promoting efficient use of resources and reducing unnecessary utilization. This helps control health care costs and ensures the long-term sustainability of the program.

MHD plays a vital role in improving health and well-being of Missouri's must vulnerable populations. By identifying opportunities to enhance care delivery and fostering a more patient-centered healthcare approach, MHD is committed to access, quality and patient-centered care. The MHD program not only helps beneficiaries achieve better health outcomes but also leads the way in innovative healthcare solutions.

Evaluation of Quality, Access and Timeliness of Health Care and Services

Through assessment of the EQR activities, this report demonstrates how MCPs are performing in delivering quality, accessible and timely care. Under 42 CFR §438.364, the EQRO provides analysis and evaluation of aggregated information on the quality and timeliness of and access to health services provided by a managed care plan, or its contractors, to Medicaid beneficiaries. These concepts are summarized below in Figure 1 and the following text.

Figure 1. Illustration of Quality, Access and Timeliness of Care.

Quality

Quality of care encompasses access and timeliness as well as the process of care delivery and the experience of receiving care. Although enrollee outcomes can also serve as an indicator of quality of care, outcomes depend on numerous variables that may fall outside the provider's control, such as patients' adherence to treatment. CMS describes quality as the degree to which a managed care organization increases the likelihood of desired health outcomes for its enrollees through its structural and operational characteristics as well as through the provision of health services that are consistent with current professional knowledge.

Access

Access to care encompasses the steps taken for obtaining needed health care and reflects the patient's experience before care is delivered. Access to care affects a patient's experience as well as outcomes and, therefore, the quality of care received. Adequate access depends on many factors, including availability of appointments, the patient's ability to see a specialist, adequacy of the health care network and availability of transportation and translation services.

Timeliness

Timeliness of care reflects the readiness with which enrollees are able to access care, a factor that ultimately influences quality of care and patient outcomes. It also reflects the health plan's adherence to timelines related to authorization of services, payment of claims and processing of grievances and appeals.

Key Observations

The following key observations are based on the results of the EQR activities.

Performance Improvement Project (PIPs)

- While the MCPs' PIPs showed overall validations ratings of moderate to high confidence indicating adherence to acceptable methodology for all phases, a majority of the PIPs failed to meet the required validation standard for producing evidence of the likelihood that significant and sustained improvement occurred.

Performance Measure Validation (PMV)

- The following measures have demonstrated statistically significant improvements in the Medicaid State Rate between MY2022 and MY2023:
    - Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)
    - Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)
    - Child and Adolescent Well-Care Visits (3-11 Years) (WCV)
    - Child and Adolescent Well-Child Visits (12-17 Years) (WCV)
    - Child and Adolescent Well-Child Visits (18-21 Years) (WCV)
    - Annual Dental Visits (Total) (ADV)
    - Lead Screening in Children (LSC)
    - Asthma Medication Ratio (Total) (AMR)
    - Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)

  - Chlamydia Screening in Women (Total) (CHL)
  - Follow-Up After Hospitalization for Mental Illness (FUH 30-day)

  The MCPs are encouraged to identify and continue those improvement efforts.
- No measures have demonstrated statistically significant declines in the Medicaid State Rate between MY2022 and MY2023.

Compliance

- MCPs demonstrated strong performance in several key areas, including:
  - Availability of services
  - Furnishing of services and timely access
  - Access and cultural considerations in services
  - Disenrollment: requirements and limitations
- MCPs showed notable deficiencies in meeting compliance standards, including:
  - Additional coordination and continuity of care requirements
  - Information requirements for all enrollees
  - Enrollee right to receive information on available provider options
  - Compliance with other federal and state laws

Recommendations for improving these standards through targeted interventions were provided to the MCPs.

Network Adequacy Validation (NAV)

Comagine Health has high confidence in the data and methods used to calculate provider network access indicator results. Overall, the network adequacy standards review and validation results indicate the MCPs have comprehensive provider networks.

Care Management (CM)

MCPs demonstrated strong performance in several key areas for both contractual requirements and clinical chart review:

- **Document Review Focus Areas**
  - Overall Care Management – The four MCPs scored 100% in five of the seven standards
  - Pregnancy/Obstetrics – The four MCPs scored 100% in four of the six standards
  - Foster Care – The one MCP providing Foster Care services scored 100% on this focus area

Significant gaps were identified in CM processes for both contractual requirements and clinical chart review:

- **Document Review**
  - General Health Plan Policy Requirements and Comprehensive Benefit Package Requirements
  - General Eligibility and Assessment for CM – Multiple Comorbid and Pregnancy/Obstetrics requirements
  - General Eligibility and Assessment for CM

- **Clinical Review** – Across all sections, technical assistance and focused improvement efforts are recommended to address these weaknesses and improve overall compliance, performance and care outcomes.

Please refer to the individual EQR activity sections of this report for additional details.

Summary of EQR Activities and Recommendations

EQR federal regulations in 42 CFR Part §438 specify the mandatory and optional activities that the EQRO must address in a manner consistent with CMS protocols.[2] In partnership with MetaStar, Comagine Health conducted Missouri's 2024 EQR activities in alignment with CMS protocols. Recommendations are provided for each EQR activity and included in the respective sections of this report. EQRO recommendations specify whether MHD (program level) or the MCPs (plan level) are responsible for addressing the recommendations. Follow-up will be included in the 2025 EQR Annual Technical Report.

Quality Strategy Effectiveness Analysis

To fulfill the requirement established by federal regulation 42 CFR Part 438 Subpart E §438.340, the Missouri Managed Care Quality Strategy created a comprehensive strategy to assess, monitor, coordinate the quality of the managed care services, and develop measurable goals and targets for continuous quality improvement.

EQR is one part of an interrelated set of quality requirements that apply to Medicaid managed care. Per 42 CFR §§ 438.364(a)(4) and 457.1250, the feedback obtained from the state's EQRO should be used by states when examining and updating the quality strategy.

Quality Strategy Effectiveness Analysis Recommendation(s)

Along with a summary of quality, access and timeliness established under 42 CFR §438.364, the EQR incorporates the CMS National Quality Strategy (NQS) into its evaluation framework of the Quality Improvement Strategy (QIS), utilizing it as a benchmark to align state-level quality initiatives with national priorities.

Overall, Missouri's QIS aligns well with CMS NQS in foundational areas including comprehensive care, stakeholder engagement, healthy equity, data-driven quality improvement targeted preventative care, and accountability and performance-based metrics. Opportunities for improvement include adopting CMS's priorities on digital interoperability, system resilience, integration of person-centered engagement, safety initiatives and advanced technological initiatives.

[2] Electronic Code of Federal Regulations. Available at: https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.

Performance Improvement Project Validation

As part of the quality assessment and performance improvement program mandated by 42 CFR §§438.330(b)(1) and 457.1240(b), Missouri MCPs must carry out PIPs annually. These requirements are also specified in sections 2.19.9(d) and 3.15.6 of the MHD MCP contract.

A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee experience. A PIP may be designed to change behavior at a member, provider and/or MCP/system level and are aimed at enhancing both clinical and nonclinical aspects within the plan.

Validation of PIPs is a required EQR activity described at 42 CFR §438.358(b)(1)(i). The intent of the PIP validation process is to ensure the PIPs contain sound methodology in its design, implementation, analysis and reporting of its results. It is crucial that PIPs have a comprehensive and logical thread that ties all aspects together.

PIP Summary of Findings and Recommendation(s)

PIP – Program Level

Based on the program level findings from the PIP validation, weaknesses or opportunities for improvement were identified for any standard that is below 90% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following validation ratings and overall score. The MCPs will benefit from technical assistance by MHD to ensure the plans meet these requirements. MCP-specific recommendations are provided in the individual MCP 2024 PIP validation reports.

- **Validation Rating 1** – Overall confidence that the PIP adhered to acceptable methodology for all phases.
    - Two of the four MCPs, for a total of three PIPs, received a rating of moderate confidence.
- **Validation Rating 2** – Overall confidence that the PIP produced evidence of significant improvement.
    - Two of the four MCPs, for a total of two PIPs validated, received a rating of moderate confidence.
    - Three of the four MCPs, for a total of four PIPs validated, received a rating of no confidence.
- **Overall score** – Aggregate score of the four MCPs' PIP submitted for validation.
    - Two of the four MCPs, for a total of three PIPs validated, received an overall score of partially met.
    - One of the four MCPs, for a total of one PIP validated, received an overall score of not met.

Please refer to the Program Level PIP EQRO Recommendation(s) for additional details.

PIP – Plan Level

Recommendations are provided when the individual MCP did not meet the scoring element for a standard. MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented corrective action plans (CAPs) since that time to address specific issues, these recommendations may not be indicative of current performance.

Please refer to the Summary of Plan Level PIP Findings for each MCP's EQRO Recommendations and additional details.

Performance Measure Validation

Federal regulations at 42 CFR §438.330(c) require states to specify standard performance measures for MCPs to include in their comprehensive Quality Assurance and Performance Improvement (QAPI) programs. Each year, the MCPs must:

- Measure and report to the state the standard performance measures specified by the state
- Submit specified data to the state which enables the state to calculate the standard performance measures; or
- A combination of these approaches.

Performance measures are used to monitor the performance of the individual MCPs at a point in time, to track performance over time, to compare performance among MCPs, and to inform the selection and evaluation of quality improvement activities. States specify standard performance measures which the MCPs must include in their QAPI program.

Performance measure validation is a required EQR activity described at 42 CFR §438.358(b)(1)(ii). The review assesses the accuracy of performance measures reported by the MCP and determines the extent to which performance measures calculated by the MCP follow state specifications and reporting requirements.

Performance Measure Validation Summary of Findings and Recommendation(s)

PMV – Program Level

Based on the program level findings from the PMV review, the following recommendations are provided to MHD for improving measure results. Recommendations are given for those aggregate measure rates below the 50th percentile.

MHD should work with the MCPs to:

- Identify and continue the improvement efforts that are driving significant improvement in most of the Well-Child Visits in First 30 Months of Life (W30) and Child & Adolescent Well-Care Visits (WCV) measures as well as the measures below:
    - Annual Dental Visits (Total) (ADV)
    - Asthma Medication Ratio (Total) (AMR)
    - Lead Screening in Children (LSC)
    - Follow-Up After Hospitalization for Mental Illness (FUH 30-day)
    - Chlamydia Screening in Women (Total) (CHL)
- Conduct a root cause analysis to identify barriers to improving the following measures:
    - Childhood Immunization Status (Combo 10) (CIS) and Immunizations for Adolescents (Combo 1) (IMA)
    - Postpartum Care (PPC)

Please refer to the Program Level PMV EQRO Recommendation(s) for additional details.

PMV – Plan Level

Recommendations were given for those measure rates below the 50th percentile for each individual MCP. MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance.

Please refer to the Summary of Plan Level PMV Findings for each MCP's EQRO recommendations.

Compliance with Standards Review

The purpose of the compliance review is to determine whether Medicaid managed care plans are following federal standards. The compliance with standards review is a required EQR activity described at 42 CFR §438.358(b)(1)(iii). CMS developed mandatory standards for MCPs, which are codified at 42 CFR 4383 and 42 CFR 4574, as revised by the Medicaid and CHIP managed care final rule issued in 2016.

Federal regulations require MCPs to have undergone a review within the three-year period preceding each annual EQR to determine MCP compliance with federal standards as implemented by the state.

Compliance Summary of Findings and Recommendation(s)

Compliance – Program Level

Based on the program level findings from the compliance with standards review, weaknesses or opportunities for improvement were identified for any standard that is below an aggregate rate of 90% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements.

- Additional coordination and continuity of care requirements (81.8%)
    - Two of the four MCPs scored 50% on this standard.
- Information requirements for all enrollees (81.8%)
    - Two of the four MCPs scored 72.7% on this standard.
- Enrollee right to receive information on available provider options (75%)
    - Three of the four MCPs received a score of 66.7% on this standard.
- Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint (76.2%)
    - Two of the four MCPs received a score of 60% or below on this standard.
- Compliance with other federal and state laws (75%)
    - One of the four MCPs received a score of 0% on this standard.
- Provider selection (86.1%)
    - Three of the four MCPs scored below 90% on this standard.

[3] Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available at: https://www.ecfr.gov/current/title-42/part-438.

[4] Electronic Code of Federal Regulations. Title 42, part 457 Allotments and Grants to States. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=60f9f0f14136be95a1cee250074ae00d&mc=true&node=pt42.4.457&rgn=div5.

- Practice Guidelines (85%)
    - Three of the four MCPs received a score of 80% on this standard.

Please refer to the Program Level Compliance EQRO Recommendation(s) section for additional details.

Compliance – Plan Level

Based on the plan level findings from the compliance with standards review, weaknesses or opportunities for improvement were identified for any individual MCP standard that is below 90% and are presented as a recommendation.

MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance.

Please refer to the Summary of Plan Level Compliance Findings section for individual MCP details.

Network Adequacy Validation

The purpose of network adequacy validation is to determine the extent to which Medicaid and CHIP MCPs comply with network adequacy requirements during the preceding 12 months set forth in 42 CFR §438.68. Validation of network adequacy is a required EQR activity described at 42 CFR §438.358(b)(1)(iv).

States are required to ensure that MCPs and CHIPs have provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across all services. According to 42 CFR §438.68, states must establish measurable network adequacy standards for MCPs that consider regional factors and the needs of their Medicaid and CHIP populations.

Network Adequacy Validation Summary of Findings and Recommendation(s)

After completing the Protocol 4 worksheets to assess MCP network adequacy, Comagine Health has high confidence in the data and methods used to calculate provider network access indicator results.

No recommendations were identified to improve the reliability or validity of the data, processes or systems used by either the MCPs or MHD to monitor network adequacy, including those related to data systems, methodologies or staffing. Overall, the network adequacy standards review and validation results indicate the MCPs have comprehensive provider networks.

Network Adequacy Validation – Program Level

Based on program-level findings from the NAV review, the following recommendations are provided to MHD. Overall, the review and validation of network adequacy standards indicate that the MCPs maintain a comprehensive provider network. Overall, the MO program review satisfied 231 out of 240 indicators for a result of 96.4% of the network adequacy standards being met.

For the provider types and specialties where the MCPs did not meet the time or distance standard, MHD should work with the MCPs to assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs, or other contributing factors.

Network Adequacy Validation – Plan Level

Recommendations were given for each MCP for those standards that were below 99.5% performance. The MHD defined standard is for 100% of enrollees to have access to a provider within the applicable travel time or distance in all categories. Any score of 99.5% and above will be rounded up to 100%. Strengths were given for those indicators at or above 99.5%, while recommendations were given for those indicators below 99.5%.

The MCP network validation review and results show:

- HB met 98.8% of the network indicators.
- HSH/SMHK met 97.5% of the network indicators.
- UHC met 97.9% of the network indicators.

Please refer to the Summary of Plan Level NAV Findings and Recommendations for each MCP's EQRO recommendations.

Care Management Program Review (Focus Study)

According to §438.358 (c)(5), states may direct their EQROs to conduct focus studies for quality improvement, administrative, legislative, or other purposes. Focus studies assess a particular aspect of clinical or nonclinical services at a point in time.

The purpose of this focus study is to identify contributing factors and key drivers, including any challenges within the MCP's CM programs. To ensure an MCP is in compliance with CM requirements in its contract with MHD, Comagine Health completed a comprehensive review of documents and clinical records provided by the MCPs.

Care Management Summary of Findings and Recommendation(s)

CM – Program Level

Based on the program level findings from the Document Review of the CM review, weaknesses or opportunities for improvement were identified for any standard that received an aggregate score below 80% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements.[5]

- **Overall CM Requirements**
  - General Health Plan Policy Requirements (66.7%)
    - Two of the three MCPs scored 50% on this standard.
  - General Eligibility and Assessment for CM (33.3%)
    - Two of three MCPs score 0% on this standard.
- **Multiple Comorbid Requirements**
  - General Eligibility and Assessment for CM (73.3%)
    - The three MCPs scored 80% or below on this standard.
- **Pregnancy/Obstetrics Requirements**

[5]SMHK was not reviewed on these standards and received a 100% score on the standards the MCP was subject to during this review, thus no recommendations were given.

  - General Eligibility and Assessment for CM (78.9%)
    - Two out of the three MCPs did not score 100% on this standard, including one of the two MCPs scoring 42.1%.
  - Transition of CM (66.7%)
    - One out of the three MCPs scored 0% on this standard.

Based on the program level findings from the clinical review section of the CM review, weaknesses or opportunities for improvement were identified for any indicator that is below 80% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following indicators and will benefit from technical assistance by MHD to ensure the plans meet these requirements.

- **Multiple Comorbid Indicators**
  - Ensure records document the member's developmental history as well as cultural and linguistic needs.
  - Ensure the member's choice to "opt out" is documented in the record for members not receiving disease management services.
  - Consider conducting face-to-face outreach for members who cannot be reached via telephone or mail.
  - Ensure care plans are shared with the member's health care provider.
  - Implement processes to complete additional outreach attempts for members who have lost contact with the CM prior to CM closure.
- **Pregnancy/Obstetrics Indicators**
  - Focus efforts to complete assessments timely.
  - Implement processes to make additional outreach attempts when telephonic attempts are unsuccessful.
- **Foster Care Indicators**
  - Ensure records include documentation of legal information and issues.
  - Focus efforts to complete assessments timely.
  - Ensure care plans are comprehensive.
  - Ensure processes for sharing care plans with the member's health care provider are documented.
  - Ensure processes for sharing care plans with the Children's Division are documented.
  - Focus effort on CM accountability for coordination by ensuring gaps in care are coordinated.

Please refer to the Program Level Care Management Review EQRO Recommendation(s) for additional details.

CM – Plan Level

Based on the plan level findings from the Document and Clinical Record Review of the CM review, weaknesses or opportunities for improvement were identified for any standard that an individual MCP scored below 80% and are presented as a recommendation.

MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance.

Please refer to the Summary of Plan Level Care Management Review Findings for individual MCP details.

Overview of Medicaid MCP Enrollment

In Missouri, the following individuals are covered and receive their services under the MHD Managed Care Program[6]:

- **Parents and Caretakers, Children, Newborns** – Individuals covered under the MHD Managed Care Program within this group are as follows:
    - **MO HealthNet for Families**
        - MO HealthNet for Families – Adult
        - MO HealthNet for Families – Children
    - **MO HealthNet for Kids – Poverty**
        - MO HealthNet for Kids – Poverty
        - MO HealthNet for Kids – Health Initiative Fund
    - **Newborns**
        - Newborns (Eligibility Only)
- **Pregnant Women** – Individuals covered under the MHD Managed Care Program within this group are as follows:
    - **MO HealthNet for Pregnant Women**
        - MO HealthNet for Pregnant Women
        - Pregnant Women – 60 days Postpartum – Medical Assistance for Families
        - Pregnant Women – 60 days Poverty
        - Pregnant Women – Poverty
        - Pregnant Woman Poverty 133% – 185% Federal Poverty Level (FPL) – Healthcare for Uninsured Families
        - Show Me Healthy Babies (SMHB) Pregnant Women – Income above 196% and up to 300% FPL
        - SMHB Unborn Child income 0% to 300% FPL
        - SMHB Postpartum
- **MO HealthNet Children in Care and Custody and Adoption Subsidy (SMHK Population)** – Individuals covered under the MHD Managed Care Program within this group are as follows:
    - **Department of Social Services Division of Family Services**
        - Title IV-E Foster Care Program
        - Title XIX Federal Financial Participation Hearing Disabled Newborns
        - Independent Foster Care Children – Age 18 up to age 26
        - Child Welfare Services – Foster Care
        - Child Welfare – Healthcare for Uninsured Families
    - **Adoption Subsidy**
        - Adoption Subsidy – Title IV - E Eligible

[6] Missouri DSS. MO HealthNet Managed Care Eligibility Groups. Available at: https://mydss.mo.gov/media/pdf/mo-healthnet-managed-care-eligibility-groups.

        - Adoption Subsidy – Federal Financial Participation
        - Adoption Subsidy – Child Welfare Services
    - **Division of Youth Services (DYS)**
        - DYS – Family and Youth Services – Foster Care
        - DYS – General Revenue
        - DYS – Poverty
        - DYS – Healthcare for Uninsured Families
- **State Children's Health Insurance Program (CHIP)**
    - CHIP 134-150% FPL – Age 1-5
    - CHIP 101-150% FPL – Age 6-18
    - CHIP 151-185% FPL – Age 1-18
    - CHIP 186-225% FPL – Age 0-18
    - CHIP 226-300% FPL – Age 0-18
    - SMHB Newborns
- **Adult Expansion Group (AEG)** – Individuals covered under the MHD Managed Care Program within this group are as follows:
    - Non-disabled adults aged 19-64 with incomes up to 138% FPL

Figure 2 shows MHD Managed Care operation in the following regions of the state of Missouri:

- **Eastern Region:** Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren and Washington counties and St. Louis City
- **Central Region:** Adair, Andrew, Atchison, Audrain, Benton, Bollinger, Boone, Buchanan, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Carter, Chariton, Clark, Clinton, Cole, Cooper, Crawford, Daviess, DeKalb, Dent, Dunklin, Gasconade, Gentry, Grundy, Harrison, Holt, Howard, Iron, Knox, Laclede, Lewis, Linn, Livingston, Macon, Maries, Marion, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Nodaway, Osage, Pemiscot, Pettis, Phelps, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Saline, Schuyler, Scotland, Scott, Shelby, Stoddard, Sullivan, Wayne and Worth counties
- **Western Region:** Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair and Vernon counties
- **Southwest Expansion:** Barry, Barton, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Lawrence, McDonald, Newton, Oregon, Ozark, Shannon, Stone, Taney, Texas, Webster and Wright counties

Figure 2. Missouri Managed Care Regions.[7]

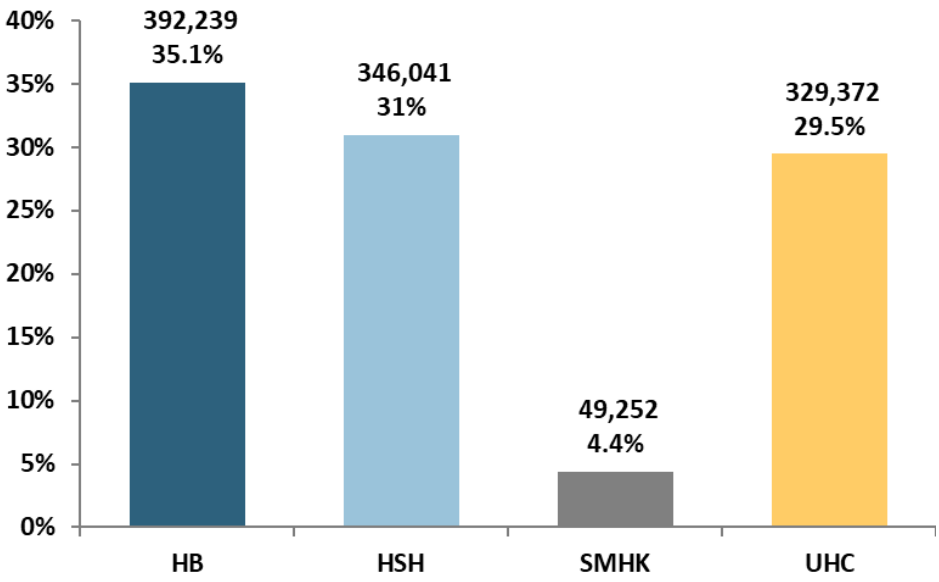
MO HealthNet Enrollment

In 2024, the four MCPs provided managed health care services for Medicaid beneficiaries who meet the eligibility requirements.

Figure 3 shows MCP Medicaid enrollment by MCP. HB represents the largest share at 35.1%, followed by HSH at 31%, UHC at 29.5% and SMHK at 4.4%, which makes up the smallest portion.

[7] Missouri DSS. Regions Map and the MO HealthNet Managed Care Health Plans. Available at: https://mydss.mo.gov/media/pdf/regions-map-and-mo-healthnet-managed-care-health-plans-each-region.

Figure 3. Percent of Total State Medicaid Enrollment, by MCP.



Managed Care Quality Strategy Effectiveness Analysis

Objective

Missouri's Managed Care Quality Improvement Strategy (QIS) is a comprehensive strategy to assess, monitor, coordinate the quality of the managed care services, and develop measurable goals and targets for continuous quality improvement.

The EQR is one part of an interrelated set of quality requirements that apply to Medicaid managed care. Feedback provided by the EQRO is reviewed when MHD updates the QIS. Per 42 CFR §§ 438.364(a)(4) and 457.1250, the feedback obtained from the state's EQRO should be used by states when examining and updating the quality strategy. The QIS is implemented through the ongoing comprehensive QAPI program that each MCP is required to establish for the services provided to members. The PIPs and performance measures included in the QAPIs are validated through the annual EQR.

Along with the summary of quality, access and timeliness established under 42 CFR §438.364, the EQR incorporates the CMS National Quality Strategy (NQS) into its evaluation framework of the QIS, utilizing it as a benchmark to align state-level quality initiatives with national priorities. The NQS provides a robust structure for promoting equity, health outcomes and system resilience across care settings, making it particularly suited to addressing the needs of Medicaid populations. By leveraging NQS priorities and measures, MHD can enhance transparency, equity and accountability in its QIS, ensuring alignment with federal guidelines and broader quality improvement efforts.

Overview

MHD's QIS focuses on monitoring, evaluation and improvement of care delivery. The Managed Care Program aims to provide effective high-quality services, ensure the satisfaction of members and involve stakeholders while achieving cost efficiencies for the state. Since the last quality strategy update in 2022, the state's Medicaid landscape has undergone significant changes. These include revised PIP requirements, updated EQR PMV, the addition of child and adult core set measures, and implementation of the EQR Prior Authorization Audit Development and Activity program. Missouri has also upgraded its network access software, providing flexible monitoring options with enhanced data and frequency. The performance withhold program was updated with slightly increased evaluation criteria beginning in state fiscal year 2024.

Additionally, Missouri has successfully implemented a new beneficiary support system, enabling participants to pay premiums online improving access to care. CMS approved a 1915(b) waiver in early 2024 for Missouri to begin the Transformation of Rural Community Health project which directs resources to rural communities. Missouri launched an initiative focused on improving maternal and infant outcomes, resulting in several key changes. The state secured approval for a State Plan Amendment extending comprehensive coverage after pregnancy through Medicaid and CHIP for postpartum individuals for 12 months, initiated the Notification of Pregnancy project, and developed Healthy Birthweight Incentive and Prenatal Care Adequacy Index programs. These changes aim to improve healthcare access, quality and timeliness.

The QIS is developed collaboratively ensuring compliance with federal and state requirements. The QIS undergoes a review and public comment process, allowing for the incorporation of feedback. Revision of the QIS occurs every three years or as necessary, based on evaluation outcomes or major program changes. All QIS documents and updates are publicly available for transparency and accountability.

An annual effectiveness review is conducted by Missouri's EQRO. The MHD review and updating of the QIS takes into account recommendations from the EQRO for improving the quality of health care services furnished by each MCP, including how MHD can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness and access to health care services furnished to MCP members. The most recent review and revision of the QIS Strategy was conducted by MHD in 2024 and incorporated feedback from the previously contracted EQRO in 2021.

MHD evaluates progress in meeting its quality strategy goals through:

- Regular audits and reviews of the MCPs' compliance with contract requirements
- Regular collection and analysis of MCP performance metrics and data
- Monitoring of MCP corrective action plans
- Active engagement throughout the EQR process

Quality Strategy Populations and Programs

The QIS is applicable to the MHD-contracted managed care offerings provided through four managed care health plans and special focused programs including:

- CHIP
- Former Foster Care Youth
- Show-Me Healthy Babies
- MHD Foster Care Specialty Plan (SMHK)

The QIS is not applicable to Medicaid fee-for-service.

Quality Strategy Mission and Vision

The QIS mission and vision provide the overall framework that informs MHD's strategy to address access to care, wellness and prevention, outcomes, cost-effective utilization of services and customer satisfaction. The vision and mission for the QIS align well with the four aims of the NQS particularly by demonstrating a commitment to health equity, focusing on measurable outcomes and an emphasis on whole-person, patient centered care.

MO HealthNet Managed Care Program Goals and Objectives

At a high level, the QIS goals relate to quality, access and timeliness of care. The QIS provides four goals that ensure Missouri managed care enrollees receive the appropriate, responsive and evidence-based health care. The four QIS goals are shown below in Table 2.

The QIS objectives further expand on the approach that MHD will take to provide oversight to ensure that the managed care program is accountable to achieving outcomes for each goal. Additionally, the QIS outlines process mechanisms created to monitor and support improvement activities on a continual basis such as the Quality Data Review committee, Quality Assessment and Improvement Advisory Group.

The CMS NQS Priority Areas and MHD QIS goals are represented in a crosswalk, in Table 2, further illustrating how the QIS goals are aligned with the national framework.

CMS National Quality Strategy Priority Areas and Goals

The CMS National Quality Strategy[8] has four priority areas, each with two goals. See below for key excerpts from the strategy.

NQS 1: Promote Aligned and Improved Health Outcomes – Ensures coordination in identifying high-priority outcomes across the Agency and in implementing quality reporting and value-based programs and policies that address these priorities.

- Goal 1 – Outcomes: Improve Quality and Health Outcomes Across the Care Journey
- Goal 2 – Alignment: Align and Coordinate Across Programs and Care Settings

NQS 2: Advance Equity and Engagement for All Individuals – Advances health equity and ensures the voices of individuals, families, and caregivers are valued and directly contribute to how CMS evaluates the impact of its programs on equity, safety and quality.

- Goal 1 – Equity: Advance Health Equity and Whole-Person Care
- Goal 2 – Engagement: Engage Individuals and Communities to Become Partners in Their Care

NQS 3: Ensure Safe and Resilient Health Care Systems – Advances CMS' renewed commitment to enabling a deeply embedded safety culture and ensuring the health care ecosystem has tools and solutions for achieving safer routine care while maintaining high safety levels in times of crisis.

- Goal 1 – Safety: Achieve Zero Preventable Harm
- Goal 2 – Resiliency: Enable a Responsive and Resilient Health Care System to Improve Quality

NQS 4: Accelerate Interoperability and Scientific Innovation – The Interoperability and Scientific Advancement priority area recognizes that improved data practices support advanced analytics, rapid-cycle feedback, and aligned quality measurement strategies that can lead to continuous improvement in person-centered care.

- Goal 1 – Interoperability: Accelerate and Support the Transition to a Digital and Data-Driven Health Care System
- Goal 2 – Scientific Advancement: Transform Health Care using Science, Analytics and Technology

The MHD QIS goals and CMS NQS Priority Areas are represented in a crosswalk, in Table 2, further illustrating how the QIS goals are aligned with the national framework.

Table 2. MHD Quality Improvement Strategy Goals and CMS National Quality Strategy Priority Areas Crosswalk.

MHD Quality Improvement Strategy*	Alignment with CMS NQS Priority Areas and Domains
QIS 1: Ensure appropriate access to care for the state's Managed Care population by monitoring appointment standards and network adequacy.	NQS 1, NQS 2 Access, Timeliness
QIS 2: Promote the health and wellness of Managed Care members through use of preventative services.	NQS 2, NQS 3 Quality, Access
QIS 3: Ensure cost-effective utilization of services.	NQS 1, NQS 2, NQS 3, NQS 4 Quality, Access, Timeliness

[8] CM National Quality Strategy. Available at: https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy

MHD Quality Improvement Strategy*	Alignment with CMS NQS Priority Areas and Domains
QIS 4: Promote member satisfaction with experience of care.	NQS 1, NQS 2 Quality, Access, Timeliness

**State of Missouri Managed Care Quality Strategy – October 2024.*[9]

Quality Strategy Evaluation

To support MHD in the continued efforts to improve managed care in the state of Missouri, Comagine Health conducts an annual review of the state's QIS and provides an assessment on the strengths and recommendations of the strategy in place.

Information and Documentation Reviewed

To better support the quality, timeliness and access to health care services provided to MCP enrollees, Comagine Health has reviewed the following information and activities to assist with targeting goals and objectives in the Quality Strategy:

- CMS National Quality Strategy
- Quality in Motion: Acting on the CMS NQS; April 2024
- 2024 State of Missouri Managed Care QIS
- Evaluation of the 2021 State of Missouri MHD QIS
- 2022 State of Missouri Managed Care QIS
- All EQRO activity results, including:
    - Performance Improvement Project Validation
    - Performance Measure Validation
    - Compliance with Standards Review
    - Network Adequacy Validation
    - Care Management Review (focused study)

2024 Strengths and Recommendations

Comagine Health acknowledges the significant effort put forth by MHD to create the QIS. Overall, Missouri's QIS aligns well with CMS NQS in foundational areas including equity, data-driven quality improvement and comprehensive care. Opportunities for improvement include adopting CMS's priorities on digital interoperability, system resilience and advanced technological initiatives. After review of the state QIS, Comagine Health has identified strengths and recommendations, as shown in Tables 3 and 4, respectively, to support MHD in improving the effectiveness of the QIS.

[9] State of Missouri Managed Care Quality Strategy – October 2024. Available at: https://mydss.mo.gov/media/pdf/2024-quality-improvement-strategy-0

Table 3. Strengths Related to the Quality Strategy.

Strengths	Linked to QIS Goal(s)*	Domain(s)
Comprehensive Care and Stakeholder Engagement: The QIS strategy highlights comprehensive care by emphasizing preventive, chronic disease and behavioral health care, aligning with the NQS's priority on whole-person care. The QIS includes multiple stakeholders in quality planning, which supports a robust, collaborative approach.	Goals 1, 2, 4	Quality Access Timeliness
Data-Driven Quality Improvement and Regular Review: The QIS integrates HEDIS, CAHPS and other data sources to guide its quality improvements, including a quarterly cadence for review meetings. The annual review by an EQRO further supports the QIS's alignment with the NQS's focus on transparency, accountability and benchmarking in quality improvement.	Goals 2, 3, 4	Quality Access Timeliness
Health Equity: The QIS's Disparities Plan for race, ethnicity and language data collection aligns well with the NQS's emphasis on health equity. The strategy targets improved outcomes for underserved populations, notably aligning with NQS's emphasis on advancing health equity through data and incentive adjustments.	Goals 1, 2, 4	Quality Access Timeliness
Targeted Preventive Care Initiatives: The QIS exhibits a proactive approach in promoting prenatal care programs such as the Prenatal Care Adequacy Index and Healthy Birthweight Incentive. This approach is aligned with the NQS's prioritization of preventive and maternal care improvements and outcomes.	Goal 2, 4	Quality Access Timeliness
Accountability and Performance-Based Metrics: The Medicaid Reform and Transformation Program includes performance incentive programs for members and providers as well as withhold programs for the MCPs. The QIS uses quality metrics to assess managed care providers, reflecting the NQS alignment priority of holding providers accountable for delivering high-quality, measurable care across services. The use of explicit benchmarks for progress tracking is also well aligned with the NQS. Additionally, the plan to display quality rating system results, quality measures, and performance data on a public website for members to review is consistent with key actions under engagement in the NQS.	Goals 3, 4	Quality Access Timeliness

Table 4. Recommendations Related to the Quality Strategy.

Recommendations	Linked to Goal(s)*	Domains
Increase Digital Interoperability: The QIS strategy lacks explicit measures or structures to support digital interoperability. In contrast, the NQS and 2024 CMS Final Rule prioritizes interoperability and digital transition to improve care coordination and accessibility of health records.	Goals 1, 3, 4	Quality Access Timeliness
Improve Resiliency Planning: In contrast to the NQS's focus on system resilience for emergency responses and climate-related events, the QIS strategy does not explicitly address health system resilience. This could be a critical gap during public health crises or extreme weather events and could worsen long-term threats to the health care system such as workforce issues.	Goals 1, 2, 3	Quality Access Timeliness

Recommendations	Linked to Goal(s)*	Domains
Enhance Integration of Person-Centered Engagement: The NQS emphasizes active engagement with individuals and communities to improve satisfaction and experience, but the QIS has limited person-reported outcome measures or initiatives to increase patients' access to their own health records. This may be particularly relevant for members accessing culturally competent care and ensuring viable mechanisms for gaining true access to that care.	Goals 2, 4	Quality Access Timeliness
Increase Safety-Oriented Initiatives: The QIS omits any explicit discussion of safety, which is a major pillar of the NQS framework. The QIS would benefit from incorporation of zero-preventable-harm initiatives such as enhanced safety protocols, tracking and public reporting of safety events, and promotion of a holistic systems-based safety focus.	Goals 2, 3	Quality Access Timeliness
Integrate Scientific and Technological Advancements: The NQS includes goals for advancing analytics and artificial intelligence, which the QIS currently does not integrate. Embracing predictive analytics and innovative technologies could enhance the QIS strategy in areas like prior authorization, population health and predictive care models.	Goal 2, 3, 4	Quality Access Timeliness

**Goals from State of Missouri Managed Care Quality Strategy – October 2024.*

Please see additional program level recommendations made to MHDs to improve MCP performance in the following sections of this Annual Technical Report. Below are the QIS goals that align with the MHD program level recommendations.

- Performance Improvement Project Validation (Goals 2, 3, 4)
- Performance Measure Validation (Goals 2, 3)
- Compliance with Standards Review (Goals 1, 3, 4)
- Network Adequacy Validation (Goals 1, 2)
- Care Management Review (Goals 3, 4)

Progress on Previous Year (2023) EQRO Recommendations

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final 2023 EQR Annual Technical Report (review period CY2022) was not available. As a result, progress cannot be identified.

Performance Improvement Project (PIP) Validation

Objectives

As part of the quality assessment and performance improvement program mandated by 42 CFR §§ 438.330(b)(1) and 457.1240(b), Missouri MCPs must carry out PIPs annually. These requirements are also specified in sections 2.19.9(d) and 3.15.6 of the MHD MCP contract.

Overview

A PIP is a project conducted by the MCP that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee experience. A PIP may be designed to change behavior at a member, provider and/or MCP/system level and are aimed at enhancing both clinical and nonclinical aspects within the plan.

Validation of PIPs is a required EQR activity described at 42 CFR §438.358(b)(1)(i). The intent of the PIP validation process is to ensure the PIPs contain sound methodology in its design, implementation, analysis and reporting of its results. It is crucial that it has a comprehensive and logical thread that ties each aspect (e.g., aim statement, sampling methodology and data collection) together.

Comagine Health conducted an assessment and validation to ensure the PIPs were designed, implemented, analyzed and reported in a methodologically sound manner.

Methodology

As required under *CMS Protocol 1 Validation of Performance Improvement Projects (PIPs)*, Comagine Health determined whether PIP validation criteria were Met, Partially Met or Not Met. In addition, Comagine Health utilizes validation ratings in reporting the results of the MCPs' PIPs.

Scoring

Each standard has a specified number of scoring elements, which correlate to the PIP validation worksheets. Element score results are presented as either "Yes," "No" or "Not Applicable (NA)" based on the reviewer's evaluation of the MCP's responses and documents submitted. Elements scored NA are not reviewed and are not included in the final scoring. Standard scores are presented as the number of "Yes" elements out of the total number of scoring elements possible for each validation rating.

For a full description of the methodology, including technical methods of data collection, description of data obtained and how the data was aggregated and analyzed, please see Appendix A: PIP Validation Methodology.

Summary of PIP Validation Results

PIP Validation Ratings

The validation ratings refer to the overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement.

Comagine Health provides two validation ratings of the PIP results:

- **Validation Rating 1:** Overall confidence that the PIP adhered to acceptable methodology for all phases. The rating is comprised of the following standards:
  - Standard 1 – Review the selected PIP topic
  - Standard 2 – Review the aim statement
  - Standard 3 – Review the identified PIP population
  - Standard 4 – Review the sampling method
  - Standard 5 – Review the selected PIP variables and performance measures
  - Standard 6 – Review the data collection procedures
  - Standard 7 – Review data analysis and interpretation of PIP results
  - Standard 8 – Assess the improvement strategies
- **Validation Rating 2:** Overall confidence that the PIP produced evidence of significant improvement. The rating is comprised of the following standard:
  - Standard 9 – Assess the likelihood that significant and sustained improvement occurred

For a full description of the validation ratings, please see Appendix A.

Tables 5-7 provide the scoring legend, summary of all MCP PIP validation ratings, overall score and an aggregate overall rating and score at the program level (MO).

Table 5. MO PIP Validation Rating and Overall Score Legend.

Percentage of Validation Steps Met	Validation Rating (Confidence Level)	Overall Score
90% – 100%	High confidence in reported results	Met
80% – 89.9%	Moderate confidence in reported results	Partially Met
70% – 79.9%	Low confidence in reported results	Not Met
≤ 69.9%	No confidence in reported results	Not Met

Table 6. MO Overall PIP Validation Rating 1.

Plan	PIP	Scoring Elements	% Score	Validation Rating
HB	Inpatient Re-admissions for Mental Health (Clinical)	38/38	100%	High confidence
HB	Improving Member Satisfaction (Nonclinical)	42/42	100%	High confidence
HSH	Maternal/Infant Health (Clinical)	41/46	89.1%	Moderate confidence
HSH	Improving Member Satisfaction (Nonclinical)	38/44	86.4%	Moderate confidence
SMHK	Inpatient Re-admissions for Mental Health (Clinical)	37/38	97.4%	High confidence
UHC	Inpatient Re-admissions for Mental Health (Clinical)	32/36	88.9%	Moderate confidence
UHC	Improving Member Satisfaction (Nonclinical)	39/43	90.7%	High confidence
MO*	**Overall PIP Program Validation Rating 1**	**267/287**	**93%**	**High confidence**

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive scores.*

Table 7. MO Overall PIP Validation Rating 2.

Plan	PIP	Scoring Elements	% Score	Validation Rating
HB	Inpatient Re-admissions for Mental Health (Clinical)	5/5	100%	High confidence
HB	Improving Member Satisfaction (Nonclinical)	4/5	80%	Moderate confidence
HSH	Maternal/Infant Health (Clinical)	1/5	20%	No confidence
HSH	Improving Member Satisfaction (Nonclinical)	1/5	20%	No confidence
SMHK	Inpatient Re-admissions for Mental Health (Clinical)	2/5	40%	No confidence
UHC	Inpatient Re-admissions for Mental Health (Clinical)	3/5	60%	No confidence
UHC	Improving Member Satisfaction (Nonclinical)	4/5	80%	Moderate confidence
MO*	**Overall PIP Program Validation Rating 2**	**20/35**	**57.1%**	**No confidence**

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive scores.*

Overall PIP Score

The overall PIP score is based on the nine individual validation standard scores. The overall score is presented as the total number of "Yes" results out of the number of scoring elements possible for each of the nine individual validation standard scores.

Table 8 shows the overall score for each MCP's PIPs.

Table 8. Aggregate MCP PIP Summary and Overall Program Results.

Plan	PIP	Validation Rating 1	Validation Rating 2	Scoring Elements	Overall Score %*	Overall Score
HB	Inpatient Re-admissions for Mental Health (Clinical)	100%	100%	43/43	100%	Met
HB	Improving Member Satisfaction (Nonclinical)	100%	80%	46/47	97.9%	Met
HSH	Maternal/Infant Health (Clinical)	89.1%	20%	42/51	82.4%	Partially Met
HSH	Improving Member Satisfaction (Nonclinical)	86.4%	20%	39/49	79.6%	Not Met
SMHK	Inpatient Re-admissions for Mental Health (Clinical)	97.4%	40%	39/43	90.7%	Met
UHC	Inpatient Re-admissions for Mental Health (Clinical)	88.9%	60%	35/41	85.4%	Partially Met
UHC	Improving Member Satisfaction (Nonclinical)	90.7%	80%	43/48	89.6%	Partially Met
MO	**Overall PIP Program Score**	**93%**	**57.1%**	**287/322**	**89.1%**	**Partially Met**

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores.*

Program Level PIP EQRO Recommendation(s)

Based on the program level findings from the PIP validation, weaknesses or opportunities for improvement were identified for any standard that is below 90% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following validation rating and overall score. The MCPs will benefit from technical assistance by MHD to ensure the plans meet these requirements. MCP-specific recommendations are provided in the individual MCP 2024 PIP validation reports.

- **Validation Rating 1** – Overall confidence that the PIP adhered to acceptable methodology for all phases (93%)
    - Two of the four MCPs, for a total of three PIPs, received a rating of moderate confidence.
- **Validation Rating 2** – Overall confidence that the PIP produced evidence of significant improvement (57.1%)
    - Two of the four MCPs, for a total of two PIPs validated, received a rating of moderate confidence.
    - Three of the four MCPs, for a total of four PIPs validated, received a rating of no confidence.
- **Overall score** – Aggregate score of the four MCPs' PIP submitted for validation (89.1%)
    - Two of the four MCPs, for a total of three PIPs validated, received an overall score of partially met.
    - One of the four MCPs, for a total of one PIP validated, received an overall score of not met.

Progress on Previous Year (2023) Program Level PIP EQRO Recommendation(s)

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Summary of Plan Level PIP Findings

The following pages provide an overview of each MCP's PIPs, including applicable domains, score, strengths, weaknesses/opportunities for improvement, validation status, validation ratings and performance measure results, if applicable.

Note: PIP weaknesses/opportunities for improvement in the tables below are provided when the MCP did not meet the scoring element and are the basis for the recommendations. This language is a synopsis from Comagine Health PIP Validation Worksheets completed for each PIP. For more detailed information on the MCPs' PIP results, please refer to the individual MCP 2024 EQR PIP validation reports.

Healthy Blue

The following results provide an overview of the clinical and nonclinical PIPs, including applicable domains, score, validation status, validation ratings and performance measure results submitted by HB.

Clinical PIP

PIP Title: Inpatient Re-admissions for Mental Health (Clinical)

Aim Statement: Between March 2023 and December 2023, HB will improve HEDIS FUH 30-day rate for Adult Expansion Group members, 19-64 years of age, from 36.69% to 38.69% through early behavioral health (BH) care manager (CM) engagement with hospitals/members and by adding an additional outreach attempt for members that were unable to be reached post discharge.

Domain(s): Timeliness and Access

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions
  1. HB's BH CMs connected with members upon admission to establish rapport, assist with connecting members to outpatient treatment or completing the follow up after hospitalization assessment, 7-day or 30-day.
  2. HB's BH CMs connected with facility upon a member's admission to BH hospitalization to complete the After-Care Planning Guidance form, assist with discharge planning and connect members with outpatient providers.
  3. HB's outreach care specialists added extra outreach at two weeks following the last attempt for Adult Expansion Group members who were unable to be reached on admission and/or discharge and a follow-up appointment was not scheduled. Licensed BH CMs were to be available to complete an internal follow-up after hospitalization appointment.

Performance Measure and Results

Table 9 shows the statistically significant rate change legend for Table 10.

Table 9. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Table 10 summarizes the performance measures of the Mental Health FUH 30-day Clinical PIP submitted for validation by HB.

Table 10. HB Clinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
HEDIS Measure – FUH 30-day rate	MY2022	NA	36.7%	MY2023	NA	41% ▲

Results: Demonstrated improvement; statistically significant change; p-value <.05

Findings

Table 11 provides the findings, along with the applicable standard, for the HB Inpatient Re-admissions for Mental Health clinical PIP.

Table 11. HB Clinical PIP Findings.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
• The performance measures were suitable given the data availability. The data collected was accurately used to inform new PDSA cycles and quality improvement efforts. Gaps were identified and addressed ensuring members received necessary support **(5)**. • During the two-week post-discharge outreaches, both outreach care specialists and licensed behavioral health care managers used the care compass CM system to document outreach efforts and follow up after hospitalization completions **(6)**. • The consistent application of defined terms throughout the project assured data comparability **(6)**. • HB presented the PIP findings clearly and concisely, ensuring that the information was easily understandable **(7)**. • HB's analysis strategy ensured consistency between initial and repeat measurements. Data collection and measurement processes were standardized to maintain uniformity throughout **(7)**. • Despite numerous attempts during the second PDSA cycle, data revealed zero successful completions leading HB to abandon the practice of two-week post-discharge outreaches. This decision illustrated the capacity to adapt based on observed outcomes **(8)**. • The initial success of the PIP can be attributed to the shift from hospital-based utilization management staff to a dedicated care management team **(8)**. • The consistent tailoring and modification of PIP interventions through validated PDSA cycles grounded the interventions in real-time data and observations **(9)**.

PIP Title: Inpatient Re-admissions for Mental Health
Weaknesses/Opportunities for Improvement
• Although the requirement for 6.1 was met, the current documentation for standard operating procedures (SOPs) in data collection lacked comprehensive detail and specificity regarding several critical aspects, which can lead to inconsistencies, data validity issues and potential miscommunication among team members **(6)**.
Recommendations
• HB did not receive any recommendations for the clinical PIP.

Nonclinical PIP

PIP Title: Improving Member Satisfaction (nonclinical)

Aim Statement: Between April 2023 and December 2023, HB will improve member satisfaction by a net of five percentage points across three domains (routine appointments, ease of getting care, rating of personal doctor) by providing real time, customized results of Post Provider Visit Surveys (PPVS) and education to targeted providers.

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions
    1. HB conducted PPVS, which were designed to mimic the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. The PPVS uses five questions that are similar to questions in the CAHPS Survey.

Performance Measure and Results

Table 12 shows the statistically significant rate change legend for Table 13.

Table 12. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbol
Increased	▲
Decreased	▼

Table 13 summarizes the performance measures of the Improving Member Satisfaction nonclinical PIP submitted for validation by HB.

Table 13. HB Nonclinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
Post Provider Visit Survey Results for the Study Group (across the three selected domains)	MY2022	198	64.1%	MY2023	115	73.9%

Results: Demonstrated improvement; no statistically significant change; p-value 0.07508

Findings

Table 14 provides the findings, along with the applicable standard, for the HB Improving Member Satisfaction nonclinical PIP.

Table 14. HB: Nonclinical PIP Findings.

PIP Title: Improving Member Satisfaction
Strengths
• HB does an excellent job defining their improvement strategy **(2)**. • HB included clear definitions of patient populations, excluded populations and a defined 90-day quarantine period **(3)**. • Member participants were selected with careful consideration of timeliness, bias and member fatigue. Providers were chosen randomly, with a process in place to address any outliers **(4)**. • Exclusions ensured the population remained accurate and manageable **(4)**. • HB utilized PPVS to measure member satisfaction and experience of care with their personal doctor allowing HB to give each provider feedback that could be used for provider specific interventions **(5)**. • HB identified provider engagement as a key lesson learned that will inform future initiatives **(7)**. • As part of the rapid-cycle PDSA approach, HB has a cross-functional workgroup with representation from a variety of disciplines within the health plan **(8)**. • When provider engagement was low, HB ended the current PDSA cycle and started a new one with a more engaged provider **(8)**. • Beginning in 2024, HB plans to refine the approach to the PPVS results by focusing efforts on the lowest-performing question for both the Study and Control Groups, Q1. Routine Care **(8)**.

PIP Title: Improving Member Satisfaction
• Although HB did not meet the state goal of +5 percentage points on the Child CAHPS Survey, sustained improvement was identified in the area of rating of personal doctor **(9)**.
Weaknesses/Opportunities for Improvement
• Although the requirement for 6.1 is met, the current documentation for SOPs in data collection lacks comprehensive detail and specificity regarding several critical aspects, which can lead to inconsistencies, data validity issues and potential miscommunication among team members **(6)**. • There is no statistical evidence that any observed improvement is the result of the intervention **(9)**.
Recommendations
• HB did not receive any recommendations for the nonclinical PIP.

Home State Health

The following results provide an overview of the clinical and nonclinical PIPs, including applicable domains, score, validation status, validation ratings and performance measure results submitted by HSH.

Clinical PIP

PIP Title: Maternal/Infant Health (clinical – medical)

Aim Statement: By December 31, 2023, HSH will decrease the percentage of low-birth weight (LBW) deliveries (defined as <2,500 grams) of at-risk African Americans in targeted ZIP codes by 1% by educating members regarding the use of harmful legal substance, and by utilizing community partners/providers for education and maternal health support.

Domain(s): Quality, Access

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions
    1. HSH initiated an intervention to partner with a community organization, to support at-risk African American pregnant women in targeted ZIP codes. HSH established a process for planning and executing the showers by collaborating with the community outreach, CM and quality departments, assigning key leaders to oversee each aspect.
    2. HSH designed an intervention involving creating an educational video with HSH's chief medical officer for the HSH website and two text message campaigns. The educational video focused on maternal care and the risks of recreational marijuana use, aiming to reduce LBW babies.
    3. HSH aimed to address the causes of preterm and LBW deliveries by focusing on hypertension and preeclampsia. Outreach efforts targeted pregnant members in specific ZIP codes to provide education and encourage discussions with their physicians about the benefits of aspirin.

Performance Measure and Results

Table 15 shows the statistically significant rate change legend for Tables 16-18.

Table 15. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Tables 16-18 summarize the performance measures of the Maternal/Infant Health clinical PIP submitted for validation by HSH. *(Note, a lower score indicates better performance for these measures.)*

Table 16. HSH: Clinical Performance Measures and Results: LBW-CH.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
CDC Child Core Set Measure; Living Birth, less than 2,500 grams (LBW-CH)	MY2022	9,617	11.6%	MY2023	9,852	11%

Results: Demonstrated improvement; no statistically significant change; p-value <.05

Table 17. HSH: Clinical Performance Measures and Results: LBW-African Americans in Target ZIP Codes.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
LBW Rates for African Americans in Target ZIP Codes	MY2022	134	12.7%	MY2023	148	25% ▲

Results: No improvement demonstrated; statistically significant change; p-value 0.000

Table 18. HSH: Clinical Performance Measures and Results: LBW Rates for African Americans.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
LBW Rates for African Americans	MY2022	2,212	17.2%	MY2023	2,175	18.1%

Results: No improvement demonstrated; no statistically significant change; p-value <.05

Findings

Table 19 provides the findings, along with the applicable standard, for the HSH Inpatient Re-admissions for Mental Health clinical PIP.

Table 19. HSH: Clinical PIP.

PIP Title: Maternal/Infant Health
Strengths
• HSH members overlapping with the LBW measure were included in the target PIP population **(4)**. • HSH conducted a comprehensive review of their performance measures, ensuring that the chosen metrics were based on the latest clinical knowledge **(5)**. • HSH provided examples of how feedback received from members and other maternal health workgroups, informed the selection and evaluation of quality improvement activities **(5)**. • Because race and ethnicity were not necessarily disclosed in all data systems, HSH used internal reporting through notification of pregnancy reports and obstetrics scorecard reports, to ensure the MCP was identifying all African American members **(5)**. • The data collection program for the intervention was robust and well automated **(6)**. • HSH provided a robust data plan with stratified metrics **(7)**. • HSH considered factors that could influence the comparability of initial and repeat measurements for their intervention by having two staff members independently review the survey results **(7)**. • By comparing results across various MCPs, HSH developed targeted interventions for the eastern region of the state **(7)**. • By providing transportation for members to attend the baby showers, HSH removed a significant barrier and demonstrated their commitment to educating their members **(7)**. • HSH identified that the physician not being from the same minority group as the target audience made the content less relatable for the target audience **(7)**. • Baby showers were designed to offer educational content in multiple languages, and members were provided access to interpreters **(8)**. • The same methodology was used for LBW-CH rates during baseline and repeat measurements. This process was validated by the Quality Outcomes Analyst IV **(9)**.
Weaknesses/Opportunities for Improvement
• Baseline and goal rates were not included in the aim statement **(2)**. • HSH did not account for non-responders **(4)**. • HSH used a convenience sampling method, which is generally discouraged because it can increase the risk of sampling error **(4)**. • The manual data collection method used can lead to validity and human error issues for some interventions **(6)**. • The analysis did not account for the gestation period of the pregnant member **(7)**.

PIP Title: Maternal/Infant Health
• Member text messages were not provided in Spanish. This may be due to vendor limitations and the member details provided by the state, which are beyond HSH's control **(8)**. • HSH could not provide quantitative evidence of improvement in process or outcomes of care regarding increased education and LBW **(9)**. • The interventions did not result in an improvement in performance **(9)**. • There is no statistical evidence supporting the intervention impacted the improvement in the PIP's overall goal **(9)**. • Sustained improvement was not obtained through repeated measurements over time **(9)**.
Recommendations
HSH had seven recommendations issued for the clinical PIP. The following standards require attention, and CAPs have been issued for HSH: • Standard 2 – Review the aim statement (83.3%) • Standard 4 – Review the sampling method (60%) • Standard 7 – Review data analysis and interpretation of PIP results (87.5%) • Standard 8 – Assess the improvement strategies (83.3%) • Standard 9 – Assess the likelihood that significant and sustained improvement occurred (20%)

Nonclinical PIP

PIP Title: Improving Member Satisfaction (nonclinical)

Aim Statement: By December 31, 2023, the percentage of members in Missouri in the HSH Medicaid population (inclusive of the general plan, or GP) and sampled in the NCQA Child Medicaid Health Plan CAHPS sample will increase two scores by reducing barriers to getting needed care through increased transportation utilization, providing oral health literacy, and obtaining member feedback related to their care to measure effectiveness of interventions.

1. Composite score Getting Needed Care will increase from 85.2% to 88.20% of respondents responding "usually" or "always."
2. Supplemental Question Rating of Dental Care will increase from 68.90% to 70.90% of respondents responding 9 or 10 (on a 10-point scale).

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions
    1. HSH aimed to enhance transportation accessibility for members following a review of grievance data from 2022 from HSH's transportation vendor.

2. This performance measure was introduced to support and encourage members to access dental care via a text message campaign. The campaign aimed to remind parents of their child's dental benefits, offering rewards for completing a dental visit, emphasizing the importance of biannual dental visits, and providing a link to help locate a dentist.

- MCP-focused interventions/system changes
    1. HSH collaborated with the Division of Youth Services and HSH CMs to enhance relationships and support gap closure for dental and other preventive screenings.

Performance Measure and Results

Table 20 shows the statistically significant rate change legend for Tables 21 and 22.

Table 20. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Tables 21 and 22 summarizes the performance measures of the Improving Member Satisfaction nonclinical PIP submitted for validation by HSH.

Table 21. HSH: Nonclinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
NCQA Childhood Member Satisfaction 5.1 CAHPS Supplemental Question Rating of Dental Care	MY2022	257	68.9%	MY2023	Not provided	69.1%

Results: Demonstrated improvement; no statistically significant change; p-value <.05

Table 22. HSH: Nonclinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
NCQA Childhood Member Satisfaction 5.1 CAHPS Survey, Composite Score Getting Needed Care	MY2022	Not provided	85.2%	MY2023	Not provided	85.5%

Results: Demonstrated improvement; no statistically significant change; p-value <.05

Findings

Table 23 provides the findings, along with the applicable standard, for the HSH Improving Member Satisfaction nonclinical PIP.

Table 23. HSH: Nonclinical PIP.

PIP Title: Improving Member Satisfaction
Strengths
• HSH's CAHPS sampling processes and submissions adhered to NCQA technical requirements **(4).** • HSH identified a gap in CAHPS survey data and used interim performance measures as a proxy to improve member satisfaction with access to care **(5).** • Data elements are clearly defined **(6).** • The data plan offers a valuable starting point for outlining HSH intervention activities **(7)**. • Callouts on the graphs were integrated appropriately to indicate when new interventions were implemented, making interpretations easy to understand and quickly digestible for the reader **(7)**.
Weaknesses/Opportunities for Improvement
• The aim statement was updated after it was submitted to MHD when intervention three was added. Consequently, the interventions for the third intervention did not match the aim statement **(3)**. • HSH did not adequately address the issue of eligible members lacking cell phones within the corresponding intervention **(4)**. • The sample method for intervention two did not assess the representativeness of the sample according to subgroups **(4)**. • Valid sampling techniques were not used to protect against bias **(4)**. • The present scope of the data analysis work undertaken was not fully documented **(7)**. • The submitted results did not include the sample size for the composite score related to "Getting Needed Care" **(7)**. • Member text messages for intervention two were not provided in the members' preferred language **(8)**. • The strategy for intervention two was not designed to account for major confounding variables **(8)**. • There is minimal quantitative improvement in both the increased CAHPS score for "Getting Need Care Composite (% Usually or Always)" and the two study facilities for "Rating of Dental Care" **(9)**. • The 0.30 reported improvement is not likely a result of the selected intervention **(9)**.

PIP Title: Improving Member Satisfaction
Recommendations
HSH had eight recommendations issued for the nonclinical PIP. The following standards require attention, and CAPs have been issued for HSH: • Standard 3 – Review the identified PIP population (50%) • Standard 4 – Review the sampling method (40%) • Standard 8 – Assess the improvement strategies (66.7%) • Standard 9 – Assess the likelihood that significant and sustained improvement occurred (20%)

Show Me Healthy Kids

The following results provide an overview of the clinical PIP, including applicable domains, score, validation status, validation ratings and performance measure results submitted by SMHK.

Clinical PIP

PIP Title: Inpatient Re-admissions for Mental Health

Aim Statement: In 12 months, SMHK will increase the rate of the NCQA HEDIS® measure Follow Up After Mental Health Discharge FUH 30-day sub measure by 2 percentage points.

Domain(s): Timeliness and Access

Validation Status: Yes

Improvement Strategies/Interventions

- Provider-focused interventions
    1. SMHK initiated an intervention aimed at enhancing primary care provider (PCP) engagement. SMHK provided education to PCPs within the network about the importance of timely follow-up after a mental health discharge.
    2. SMHK aimed to implement a Psychiatric Collaborative Care model in partnership with a federally qualified health center. This model was designed to facilitate access to follow-up visits within the PCP's office by addressing barriers, including difficulties in accessing behavioral health (BH) providers within the 30-day window, stigma and the need for specialized BH care.
- MCP-focused interventions/system changes
    1. SMHK aimed to address lack of effective coordination and communication between the discharging facility and outpatient practitioners, the state of Missouri mandated the use of the Aftercare Planning Guide (APG) form. The initial intervention involved implementing the APG form across inpatient facilities within the network that treat members for BH diagnoses.

Performance Measure and Results

Table 24 shows the statistically significant rate change legend for Table 25.

Table 24. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbol
Increased	▲
Decreased	▼

Table 25 summarizes the performance measures of the Inpatient Re-admissions for Mental Health Clinical PIP submitted for validation by SMHK.

Table 25. SMHK: Clinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
HEDIS Measure – FUH 30-day rate	MY2022	1,294	63%	MY2023	2,667	74.3% ▲

Results: Demonstrated improvement; statistically significant change; p-value < 0.01

Findings

Table 26 provides the findings, along with the applicable standard, for the SMHK Inpatient Re-admissions for Mental Health clinical PIP.

Table 26. SMHK: Clinical PIP.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
• SMHK demonstrated a strong commitment to learning from past performance and continuously improving their FUH 30-day rate **(7).** • The improvement strategies were designed to address the identified barriers to quality improvement by focusing on interventions for both members and providers **(8).** • The improvement strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes **(8)**. • In 2023, SMHK tirelessly worked to implement the Psychiatric Collaborative Care model with a federally qualified health center **(8)**.
Weaknesses/Opportunities for Improvement
• Baseline and goal rates were not included in the original aim statement **(2).** • Although SMHK's HEDIS FUH 30-day rate exceeded the 2-percentage point goal, it is not likely due to the selected interventions **(9)**.

PIP Title: Inpatient Re-admissions for Mental Health
• Sustained improvement was not identified by SMHKs **(9)**. The 0.30 reported improvement is not likely a result of the selected intervention **(9).**
Recommendations
SMHK had one recommendation issued for the clinical PIP. The following standards require attention, and CAPs have been issued for SMHK: • Standard 2 – Review the aim statement (83.3%) • Standard 9 – Assess the likelihood that significant and sustained improvement occurred (40%)

UnitedHealthcare

The following results provide an overview of the clinical and nonclinical PIP, including applicable domains, score, validation status, validation ratings and performance measure results submitted by UHC.

Clinical PIP

PIP Title: Inpatient Re-admissions for Mental Health (Clinical)

Aim Statement: Improve overall rates of HEDIS® FUH 30-day by one percentage point from 45.82% to 46.82% from February 3, 2023, through December 31, 2023, with a focus on the Black/African American population in Temporary Assistance for Needy Families (TANF) and Expansion product ages 6 to 65 in the state of Missouri by enhancing care management outreach to extend beyond state contractual due diligence requirements.

Domain(s): Timeliness and Access

Validation Status: Yes

Improvement Strategies/Interventions

- Member-focused interventions
    1. UHC designed an initiative to enhance care managers outreach to unreachable members with the intent to offer additional support and schedule a behavioral health follow-up visit within 30 days of discharge.
- Provider-focused interventions
    1. At the end of June 2023, UHC created a collaboration email box for SSM Health (SSM) St. Joseph and SSM DePaul.
- MCP-focused interventions/system changes
    1. UHC team leads monitored the facility admissions and contacted facility partners via email. Communication included the assigned behavioral health care manager, their contact information and an opportunity for one-on-one communication between the hospital discharge planner and health plan care manager.

Performance Measure and Results

Table 27 shows the statistically significant rate change legend for Table 28.

Table 27. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Table 28 summarizes the performance measures of the Inpatient Re-admissions for Mental Health clinical PIP submitted for validation by UHC.

Table 28. UHC: Clinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
HEDIS Measure – FUH 30-day rate	MY2022	3,097	45.8%	MY2023	3,908	45.5%

Results: No improvement demonstrated; no statistically significant change; p-value 0.755

Findings

Table 29 provides the findings, along with the applicable standard for the UHC Inpatient Re-admissions for Mental Health clinical PIP.

Table 29. UHC: Clinical PIP.

PIP Title: Inpatient Re-admissions for Mental Health
Strengths
• UHC put procedures into place, such as weekly meetings and a good communication plan, to try and eliminate human data collection errors **(6)**. • Data elements are clearly defined **(6)**. • Baseline data and goals were defined in the PIP aim statement and provided in the data submitted in **(7)**. • When rates were used, the numerator and denominator are clearly labeled. Repeat measurements were conducted monthly. Chi-square test was used for analysis of the project **(7)**. • The rate of scheduled appointments improved for both the African American and Caucasian populations from July to December 2023 **(9)**. • It is reasonable to conclude that the improved scheduling rates were a result of the selected interventions, specifically the increased care coordination with the hospital discharge planners and health plan care managers **(9)**.

PIP Title: Inpatient Re-admissions for Mental Health
Weaknesses/Opportunities for Improvement

- Weaknesses were identified in several areas of the study design including the observations below:
  - Aim drift was observed with the second intervention.
  - The provided graph titled “Facility Compliance Rates 2022” lack data elements crucial for supporting the study's narrative and understanding the full scope of the problem **(3)**.
- UHC changed the population focus from the Black/African American population to all members. This led the interventions for the second phase of the project to misalign with the aim statement **(3)**.
- Several weaknesses were found related to the selected PIP variables and performance measures:
  - All intervention performance measures were not as clearly defined as those found in Data Analysis Plan FUH 2023 document.
  - An opportunity was missed for collaboration and overall improvement by not comparing the rates of SSM DePaul and SSM St. Joseph with those of other hospitals.
  - Performance measures were not utilized to inform new interventions or evaluate quality improvement activities.
  - Strong clinical evidence demonstrating that the process being measured has a meaningful association with outcomes was not included **(5)**.
- Specific intervention performance measures were not clearly defined and are included in the Data Analysis Plan FUH 2023 document. UHC did not compare the rates of SSM DePaul and SSM St. Joseph with those of other hospitals **(5)**.
- Current documentation for standard operating procedures (SOPs) for data collection lacks comprehensive detail and specificity regarding several critical aspects **(6)**.
- An opportunity may have been missed to utilize patient evaluations in identifying barriers for individuals who may not attend follow-up appointments **(6)**.
- Subject variability was introduced when UHC changed the control and study groups for the second intervention from Black/African American TANF and Expansion members to all members **(7)**.
- Participant selection was a threat to the internal validity of the selected PIP. Participants in the control and study group were changed mid-project and cannot be accurately compared **(7)**.
- There is no statistical evidence that the intervention had significant improvements in FUH 30-day rates **(9)**.
- Although the SSM St. Joseph FUH 30-day rate showed improvement, the SSM DePaul rate declined during the same period. As a result, sustained improvement was not achieved **(9)**.

PIP Title: Inpatient Re-admissions for Mental Health
Recommendations
UHC had five recommendations issued for the clinical PIP. The following standards require attention, and CAPs have been issued for UHC: • Standard 3 – Review the identified PIP population (50%) • Standard 5 – Review the selected PIP variables and performance measures (85.7%) • Standard 7 – Review data analysis and interpretation of PIP results (75%) • Standard 9 – Assess the likelihood that significant and sustained improvement occurred (60%)

Nonclinical PIP

PIP Title: Improving Member Satisfaction (nonclinical)

Aim Statement: Improve member satisfaction scores for three defined CAHPS® survey measures by at least five percentage points or sustain ≥ 75th national percentile by the end of MY2023 (reported out August 2024).

Domain(s): Quality

Validation Status: Yes

Improvement Strategies/Interventions

- Provider-focused interventions
    1. UHC implemented an intervention to gather qualitative feedback from members on their providers' communication styles. Feedback was then shared with providers.
    2. UHC implemented self-paced care coordination education modules for providers that had more than 100 UHC Medicaid members. The education modules were delivered through the Press Ganey app.
- MCP-focused interventions/system changes
    1. UHC used the Amplifier knowledge assessment to gauge customer service representative gaps on certain topics important to their role. The assessment provided UHC with overall trends and individualized coaching opportunities. Subsequent PDSA cycles incorporated the Net Promoter Score (NPS) and User Experience Surveys (UES) to assess whether member satisfaction levels improved as a result of the targeted coaching interventions.

Performance Measure and Results

Table 30 shows the statistically significant rate change legend for Tables 31-33.

Table 30. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Tables 31-33 summarize the performance measures of the Improving Member Satisfaction nonclinical PIP submitted for validation by UHC and the applicable standard.

Table 31. UHC: Clinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
CAHPS Survey; Improve Customer Service: Provided information or help	MY2022	57	78.9%	MY2023	64	79.7%

Results: Demonstrated improvement; no statistically significant change; p-value <.05

Table 32. UHC: Clinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
CAHPS survey: Rating of Personal Doctor	MY2022	345	76.2%	MY2023	356	75.6%

Results: No improvement demonstrated; no statistically significant change; p-value <.05

Table 33. UHC: Clinical Performance Measures and Results.

Performance Measure	Baseline Year	Baseline Sample Size	Baseline Rate	Most Recent Remeasurement Period	Most Recent Sample Size	Most Recent Rate
CAHPS Survey: Coordination of Care	MY2022	116	85.3%	MY2023	119	86.6%

Results: Demonstrated improvement; no statistically significant change; p-value <.05

Findings

Table 34 provides the findings, along with the applicable standard for the UHC Improving Member Satisfaction nonclinical PIP.

Table 34. UHC: Nonclinical PIP.

PIP Title: Improving Member Satisfaction
Strengths
• UHC recognized annual CAHPS measures would not provide timely insights and implemented a revised strategy involving analysis of more frequent performance measurements, using monthly NPS and UES assessments **(5)**. • Systems were put into place to ensure data integrity of the manual data collection **(6)**. • UHC's demonstrated data analysis strengths for the customer service initiative related to continued monitoring of the performance measures **(7)**. • To increase customer service outcomes, UHC took a careful approach centered on root cause analysis and data-driven insights **(8)**. • It is very likely UHC will see an increase in CAHPS scores in 2024 based on their continued customer services interventions and commitment to improvement **(9)**.
Weaknesses/Opportunities for Improvement
• The aim statement for UHC's PIP lacks specificity regarding the target population for the initiative **(2)**. • The PIP aim statement does not specify the population for the PIP as the members of UHC **(2)**. • UHC's sampling design for the PIP lacked the specification of the confidence intervals that were to be utilized for the study **(4)**. • While lessons learned are identified, there is a gap in systematically converting these insights into actionable opportunities and initiatives for ongoing improvement **(7)**. • Per the MCP's response, results were not compared against different entities **(7)**. • Statistical significance was not identified from 2022 to 2023 **(9)**.
Recommendations
UHC had four recommendations issued for the nonclinical PIP. The following standards require attention, and CAPs have been issued for UHC: • Standard 2 – Review the aim statement (66.7%) • Standard 4 – Review the sampling method (80%) • Standard 7 – Review data analysis and interpretation of PIP results (87.5%) • Standard 9 – Assess the likelihood that significant and sustained improvement occurred (80%)

Progress on Previous Year (2023) Plan Level EQRO Recommendations

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Performance Measure Validation

Objective

Federal regulations at 42 CFR §438.330(c) require states to specify standard performance measures for MCPs to include in their comprehensive QAPI programs. Each year, the MCPs must:

- Measure and report to the state the standard performance measures specified by the state;
- Submit specified data to the state which enables the state to calculate the standard performance measures; or
- A combination of these approaches.

Performance measures are used to monitor the performance of the individual MCPs at a point in time, to track performance over time, to compare performance among MCPs, and to inform the selection and evaluation of quality improvement activities. States specify standard performance measures which the MCPs must include in their QAPI program. Note: these measures fall under the domains of quality, access and timeliness of health care and services. For this mandatory EQR activity, MetaStar, under contract with Comagine Health, completed the Performance Measure Validation.

Overview

Performance measure validation is conducted according to federal protocol standards, *CMS Protocol 2. Validation of Performance Measures*. The review assesses the accuracy of performance measures reported by the MCP and determines the extent to which performance measures calculated by the MCP follow state specifications and reporting requirements. Assessment of an MCP's information system is required as part of performance measures validation and other mandatory review activities. To meet this requirement, each MCP receives an Information Systems Capabilities Assessment (ISCA) once every three years as directed by MHD. The next MCP ISCA is scheduled to be conducted in CY2025 in the 2025 Annual Technical report.

NCQA HEDIS® measures are standardized performance measures developed by NCQA and used to objectively measure, report and compare quality across health plans. Percentiles are used to represent the relative performance of health plans compared to other health plans and help assess how well a plan performs on various quality measures.

The performance measures for Measure Year MY2022 and MY2023, reported in CY2024, are identified in the *Quality Improvement Strategy – 2022 State of Missouri MO HealthNet Division*. Appendix 1 of the strategy, Goals, Objectives and Measures includes 15 measures related to promoting wellness and prevention under Goal 2:

- **Objective: Promote Child Health**
  - Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)
  - Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)
  - Child & Adolescent Well-Care Visits (3-11 Years) (WCV)
  - Child & Adolescent Well-Care Visits (12-17 Years) (WCV)
  - Child & Adolescent Well-Care Visits (18-21 Years) (WCV)
  - Annual Dental Visits (Total) (ADV)

  - Childhood Immunization Status (Combo 10) (CIS)
  - Immunizations for Adolescents (Combo 1) (IMA)*
  - Lead Screening in Children (LSC)
- **Objective: Promote Chronic Disease Management**
  - Asthma Medication Ratio (Total) (AMR)
  - Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)
- **Objective: Promote Women's Health**
  - Timeliness of Prenatal Care (PPC)
  - Postpartum Care (PPC)
  - Chlamydia Screening in Women (Total) (CHL)
- **Objective: Improve Management of Behavioral Health & Substance Use Disorder**
  - Follow-Up After Hospitalization for Mental Illness (FUH 30-day)

**Note: MHD's quality improvement strategy for measurement year 2023 is intended to include Immunizations for Adolescents (Combo 2) (IMA). This report includes data and analysis for Combo 1. The 2025 EQR Annual Technical Report will be updated to align with the state's quality improvement strategy and include Combo 2.*

Methodology

According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. The performance measures identified by MHD are NCQA HEDIS measures, which are validated by a certified NCQA HEDIS auditor. Comagine Health did not validate the measures but performed an analysis of the reported results as presented in the final audit reports of the MCP HEDIS Compliance Audits.

Performance measure validation was conducted through the NCQA HEDIS Compliance Audits.

Scoring

Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles:

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 75th and 50th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

For a full description of the methodology, including technical methods of data collection, description of data obtained and how Comagine Health aggregated and analyzed the data, please see Appendix B.

Summary of PMV Results

Comagine Health compared the MCPs' performance on national HEDIS measures with national benchmarks, which are published annually by NCQA in the *Quality Compass®*[10] report and are used with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid HMO plans and Medicaid HMO plans that are either required to report HEDIS measures by the state agency responsible for monitoring managed Medicaid performance or opt to publicly report their HEDIS rates. The HEDIS measures reported to NCQA vary by plan. These national benchmarks reflect the average of the plans that reported the benchmark and are not a true national average of all managed Medicaid plans. Also, note these plans represent states with and without Medicaid expansion coverage.

The licensing agreement with NCQA limits the number of benchmarks that can be published each year. The current agreement limits publication to two benchmarks for 15 measures. A licensing agreement exists for both MY2022 and MY2023. The two benchmarks selected are the national 50th percentile and the national 75th percentile.

In addition to the national benchmarks, Comagine Health calculated the Medicaid State Rate for each measure. The MY2023 Medicaid State Rate for a given measure is calculated using the reported data from the four MCPs (HB, HSH, SMHK and UHC) for that measure. The MY2022 Medicaid State Rate for each measure does not include SMHK, as the plan was initiated in July 2022, providing only a partial year of data. In order to determine the significance of year-to-year results, a Pearson's chi-squared test was used to evaluate the statistical significance for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the MCP or whether changes were due to normal variation.[11] For more information on interpreting results, see Appendix B: PMV Methodology.

Summary of Plan Level PMV Results

Results are categorized into strength, compliant and opportunity for improvement based on the national percentiles. A strength is identified as a measure rate above the 75th percentile. Compliant is any measure rate between the 75th and 50th percentile. Opportunity for improvement is a measure rate below the 50th percentile.

Table 33 identifies the MCPs' rates achieved in MY2022 and MY2023. The MY2023 rates are compared to the 50th and 75th percentile national benchmarks from MY2022 by measure.

Promote Child Health

Promoting child health is essential to a child's overall well-being and development. Child health prevention and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. These measures reflect access and quality.

The results for each child health promotion measure reported by the MCPs in MY2022 and MY2023 are compared to the Medicaid State Rate and national benchmarks of the 50th percentile and

[10] Quality Compass® is a registered trademark of NCQA.

[11] A Pearson's chi-squared test is a statistical test used to compare categorical variables. This test evaluates how likely it is that any observed difference between data sets occurred by normal variation or chance.

75th percentile from MY2023 (Table 36). Year-to-year results were analyzed for significant change using statistical testing.

The results for each measure are summarized below. Findings are categorized into a strength, meeting standards (compliant) or opportunity for improvement based on the national percentiles. Please refer to the scoring legend below.

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 75th and 50th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

Table 35 shows the statistically significant rate change legend for Table 36.

Table 35. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Table 36. Promote Child Health MCP Results.

Measure	MY2022 Medicaid State Rate	MY2023 Medicaid State Rate	50th Percentile	75th Percentile	HB*	HSH*	SMHK*	UHC*
Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)	54.1%	56.9%▲	58.4%	63.3%	57.3%▲	57.8%▲	64.8%	55%▲
Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)	57.2%	60%▲	66.8%	71.3%	60.3%	60%▲	74%	58.3%▲
Child & Adolescent Well-Care Visits (3-11 Years) (WCV)	44.5%	48.7%▲	55.7%	62.9%	48.2%▲	48.4%▲	58.8%▲	47.4%▲
Child & Adolescent Well-Care Visits (12-17 Year) (WCV)	39.4%	43.2%▲	49.2%	56.3%	43%▲	43.1%▲	53.2%▲	40.6%▲
Child & Adolescent Well-Care Visits (18-21 Years) (WCV)	18%	21.6%▲	24%	29.2%	21.4%▲	23.1%▲	20.9%	20.7%▲
Annual Dental Visits (Total) (ADV)	42.2%	47%▲	49.9%	56.4%	45.9%▲	47.9%▲	55.5%▲	45.4%▲

Measure	MY2022 Medicaid State Rate	MY2023 Medicaid State Rate	50th Percentile	75th Percentile	HB*	HSH*	SMHK*	UHC*
Childhood Immunization Status (Combo 10) (CIS)	21.4%	18.5%	30.9%	37.6%	21.2%	16.8%	14.4%▼	21.7%
Immunizations for Adolescents (Combo 1) (IMA)	42.7%	50%	80.5%	85.4%	52.8%	51.2%	53.5%▼	49.9%
Lead Screening in Children (LSC)	52.1%	57.9%▲	62.8%	70.1%	56.4%	57.3%▲	64.9%▲	55%

**MCP results are for MY2023.*

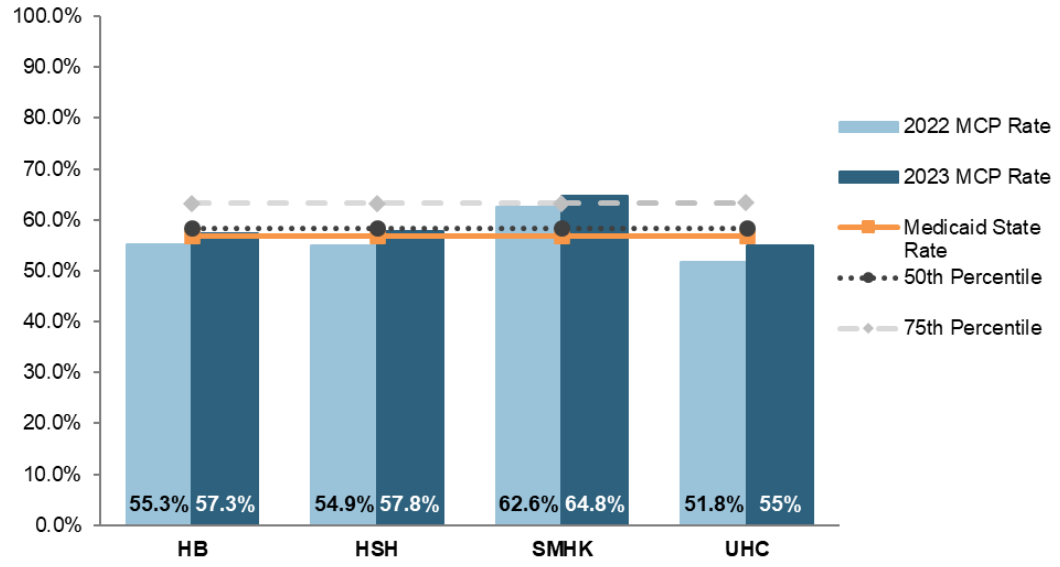
Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)

Figure 4 displays the results for *Well-Child Visits in First 30 Months of Life (0-15 Months) (W30)*. This measure is the percentage of children who turned 15 months old during the measurement year and had six or more well-child visits.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 4. Well-Child Visits in First 30 Months of Life (0-15 Months) (W30).



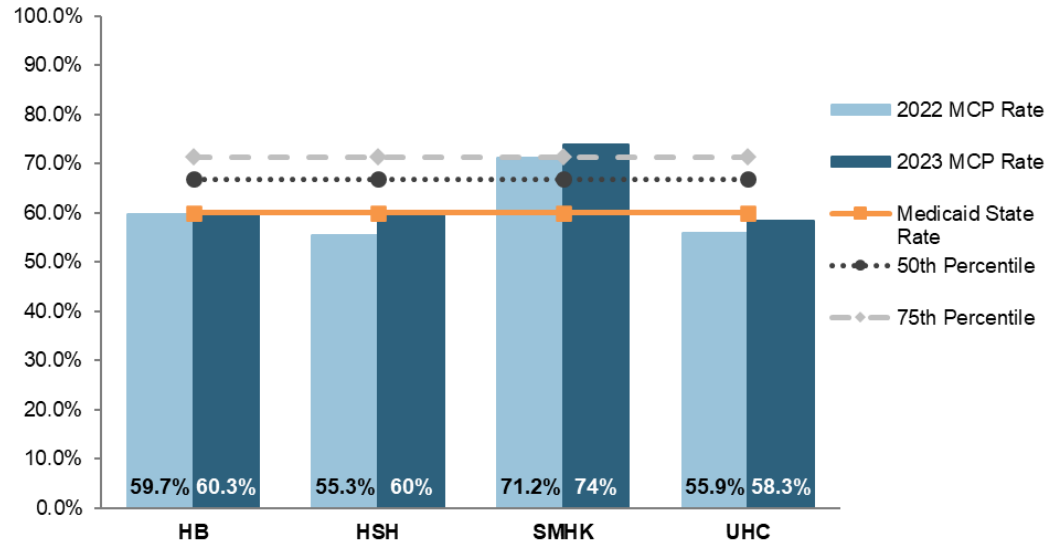
Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)

Figure 5 displays the results for *Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)*. This measure is the percentage of children who turned 30 months old during the measurement year and had two or more well-child visits.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 5. Well-Child Visits in First 30 Months of Life (15-30 Months) (W30).



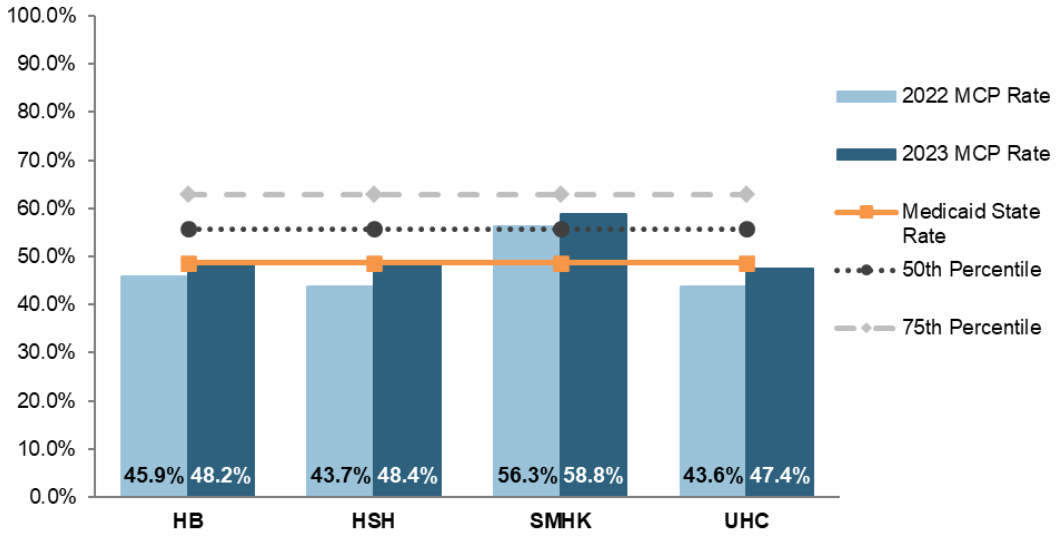
Child & Adolescent Well-Care Visits (3-11 years) (WCV)

Figure 6 displays the results for *Child & Adolescent Well-Care Visits (3-11 years) (WCV)*. This measure is the percentage of members ages 3-11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 6. Child & Adolescent Well-Care Visits (3-11 Years) (WCV).



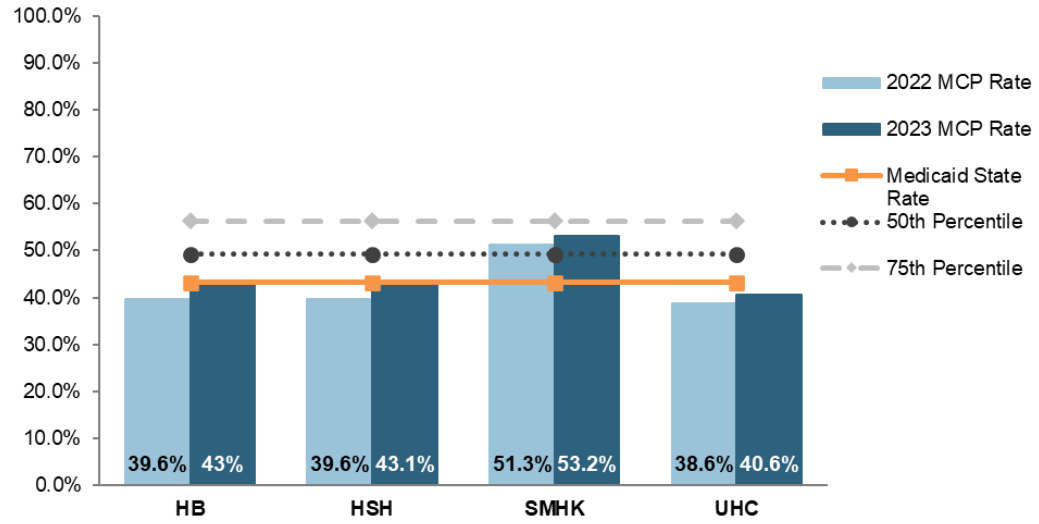
Child & Adolescent Well-Care Visits (12-17 years) (WCV)

Figure 7 displays the results for *Child & Adolescent Well-Care Visits (12-17 years) (WCV)*. This measure is the percentage of members ages 12-17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 7. Child & Adolescent Well-Care Visits (12-17 Year) (WCV).



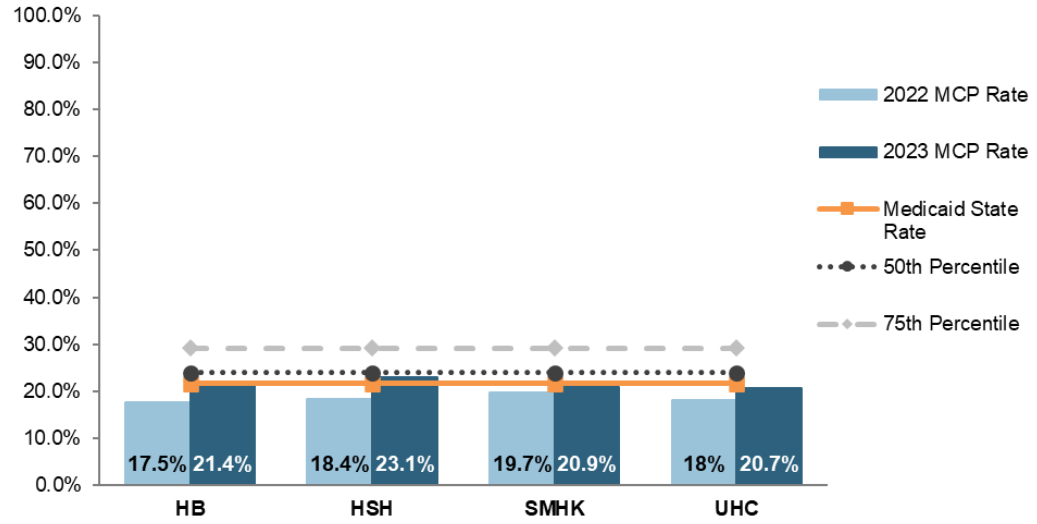
Child & Adolescent Well-Care Visits (18-21 years) (WCV)

Figure 8 displays the results for *Child & Adolescent Well-Care Visits (18-21 years) (WCV)*. This measure is the percentage of members ages 18-21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 8. Child & Adolescent Well-Care Visits (18-21 Years) (WCV).



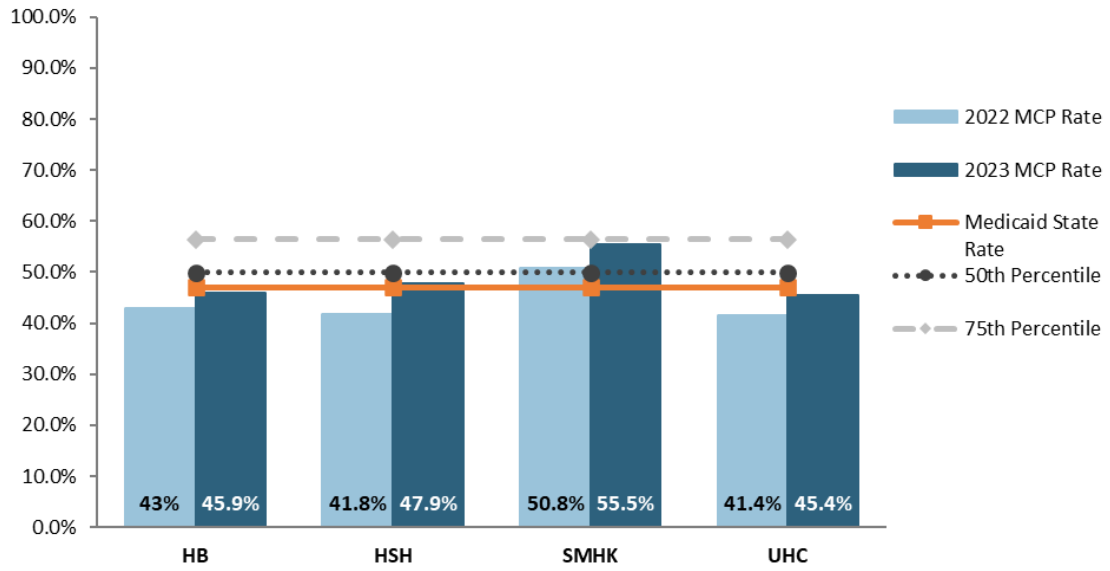
Annual Dental Visits (Total) (ADV)

Figure 9 displays the results for *Annual Dental Visits (Total) (ADV)*. This measure is the percentage of members 2–20 years of age who had at least one dental visit during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 9. Annual Dental Visits (Total) (ADV).



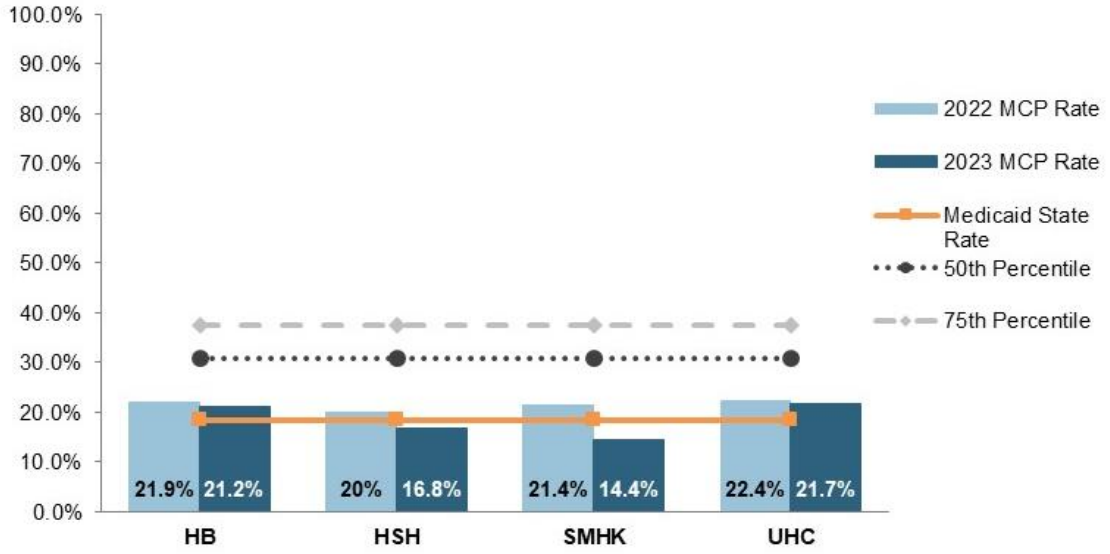
Childhood Immunization Status (Combo 10) (CIS)

Figure 10 displays the results for *Childhood Immunization Status (Combo 10) (CIS)*. This measure is the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated no statistically significant change in the Medicaid State Rate between MY2022 and MY2023 and that any change in rates is likely due to normal variation or chance.

Figure 10. Childhood Immunization Status (Combo 10) (CIS).



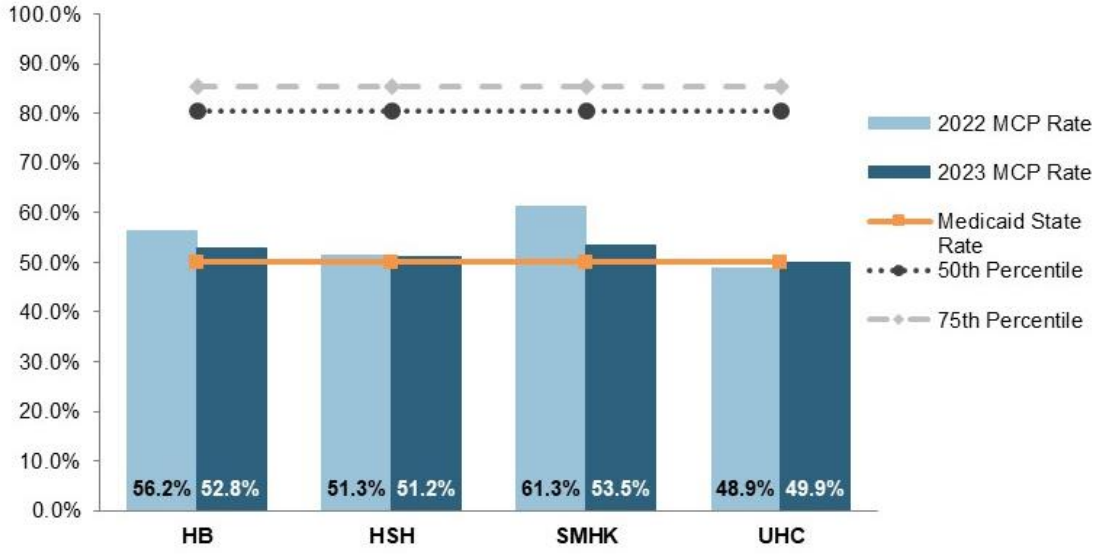
Immunizations for Adolescents (Combo 1) (IMA)

Figure 11 displays the results for *Immunizations for Adolescents (Combo 1) (IMA)*. This measure is the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated no statistically significant change in the Medicaid State Rate between MY2022 and MY2023 and that any change in rates is likely due to normal variation or chance.

Figure 11. Immunizations for Adolescents (Combo 1) (IMA).



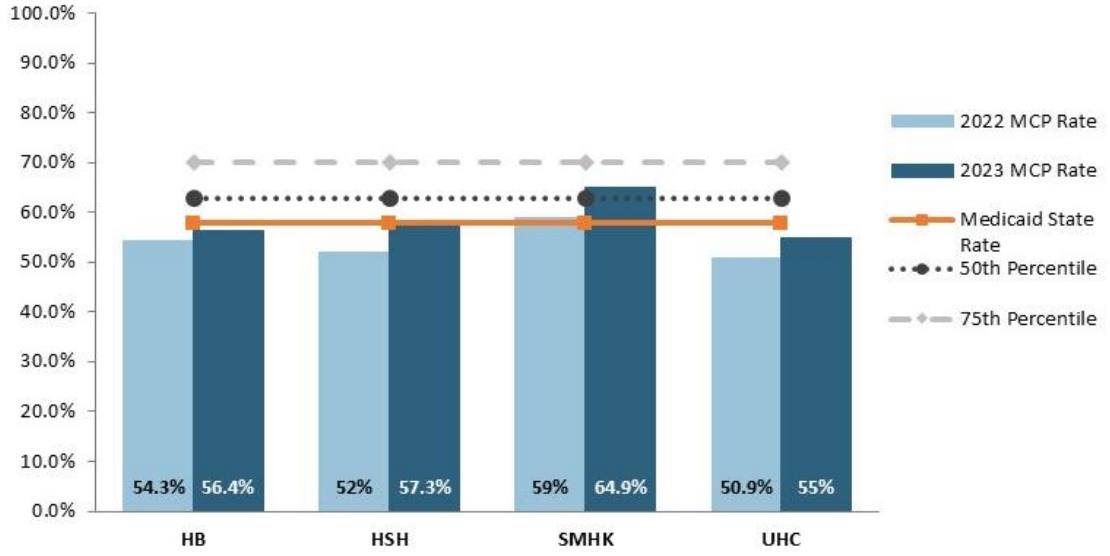
Lead Screening in Children (LSC)

Figure 12 displays the results for *Lead Screening in Children (LSC)*. This measure is the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 12. Lead Screening in Children (LSC).



Promote Chronic Disease Management

Chronic disease management measures relate to whether enrollees with chronic conditions receive adequate outpatient management services to prevent worsening of chronic conditions and more costly inpatient and emergency department services. These measures reflect access and quality.

The results for each chronic disease promotion measure reported by the MCPs in MY2022 and MY2023 are compared to the Medicaid State Rate and national benchmarks of the 50th percentile and 75th percentile from MY2023 (Table 35). Year-to-year results were analyzed for significant change using statistical testing.

The results for each measure are summarized below. Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles. Please refer to the scoring legend below.

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 75th and 50th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

Table 37 shows the statistically significant rate change legend for Table 38.

Table 37. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Table 38. Promote Chronic Disease Management MCP Results.

Measure	MY2022 Medicaid State Rate	MY2023 Medicaid State Rate	50th Percentile	75th Percentile	HB*	HSH*	SMHK*	UHC*
Asthma Medication Ratio (Total) (AMR)	54.6%	62%▲	65.6%	70.8%	65.2%▲	60.7%▲	68.2%▲	59.4%▲
Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)	47.7%	53%▲	52.3%	57.2%	56.2%▲	51.6%▲	41.7%	55.2%▲

**MCP results are for MY2023.*

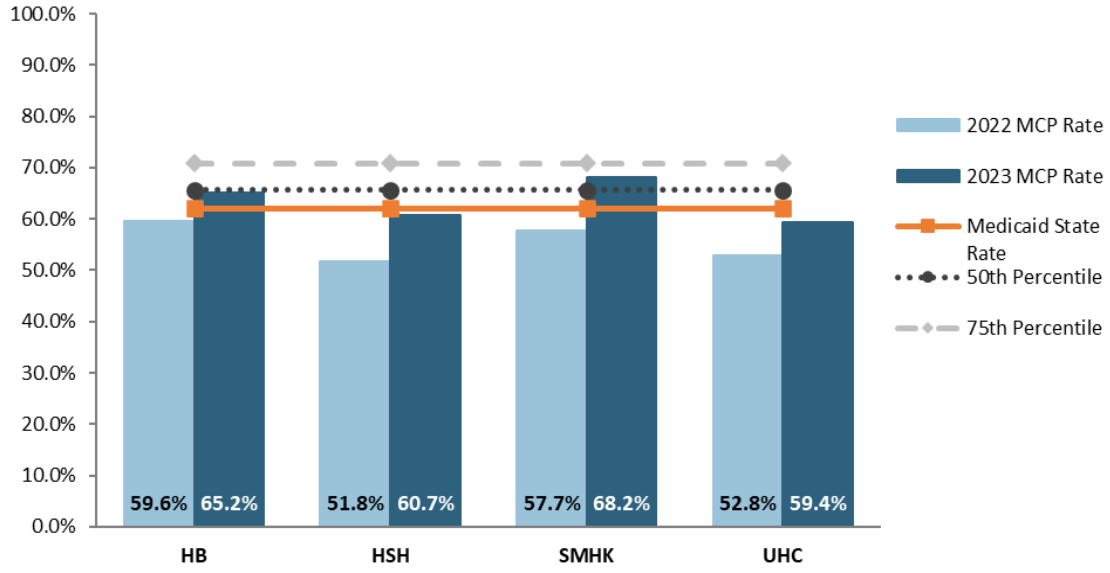
Asthma Medication Ratio (Total) (AMR)

Figure 13 displays the results for *Asthma Medication Ratio (Total) (AMR)*. This measure is the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 13. Asthma Medication Ratio (Total) (AMR).



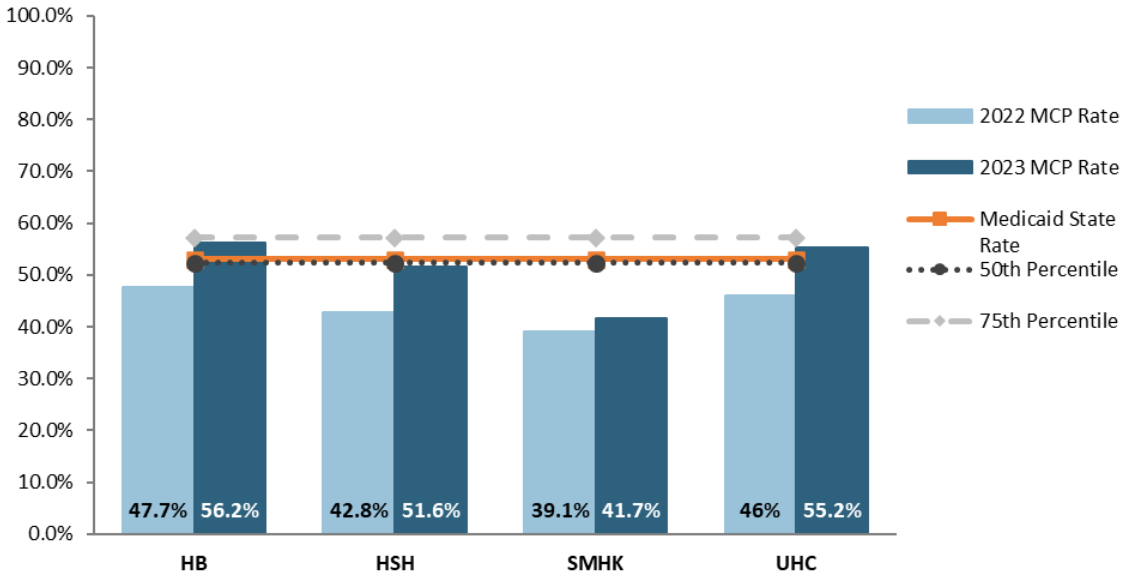
Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)

Figure 14 displays the results for *Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)*. This measure is the percentage of members 18–75 years of age with diabetes (Type 1 and Type 2) who had HbA1c Control (<8%).

Results for the measure indicated compliant practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 14. Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD).



Promote Women's Health

Women's health prevention and screening measures relate to whether enrollees receive adequate preventive care needed to prevent chronic conditions or other acute health problems. Also included in this section are measures related to adequate prenatal and postpartum care, which are essential for positive pregnancy outcomes. These measures reflect access and quality.

The results for each women's health promotion measure reported by the MCPs in MY2022 and MY2023 are compared to the Medicaid State Rate and national benchmarks of the 50th percentile and 75th percentile from MY2023 (Table 37). Year-to-year results were analyzed for significant change using statistical testing.

The results for each measure are summarized below. Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles. Please refer to the scoring legend below.

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 75th and 50th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

Table 39 shows the statistically significant rate change legend for Table 40.

Table 39. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Table 40. Promote Women's Health MCP Results.

Measure	MY2022 Medicaid State Rate	MY2023 Medicaid State Rate	50th Percentile	75th Percentile	HB*	HSH*	SMHK*	UHC*
Timeliness of Prenatal Care (PPC)	85.4%	83.7%	78.1%	82%	88.1%	80.3%	80.8%	84.9%
Postpartum Care (PPC)	75.9%	77.6%	84.2%	88.3%	81.3%	72%	75.5%	81.3%▲
Chlamydia Screening in Women (Total) (CHL)	46.3%	47.8%▲	56%	62.9%	39.6%▼	53.5%▲	53.2%	51.4%▲

**MCP results are for MY2023.*

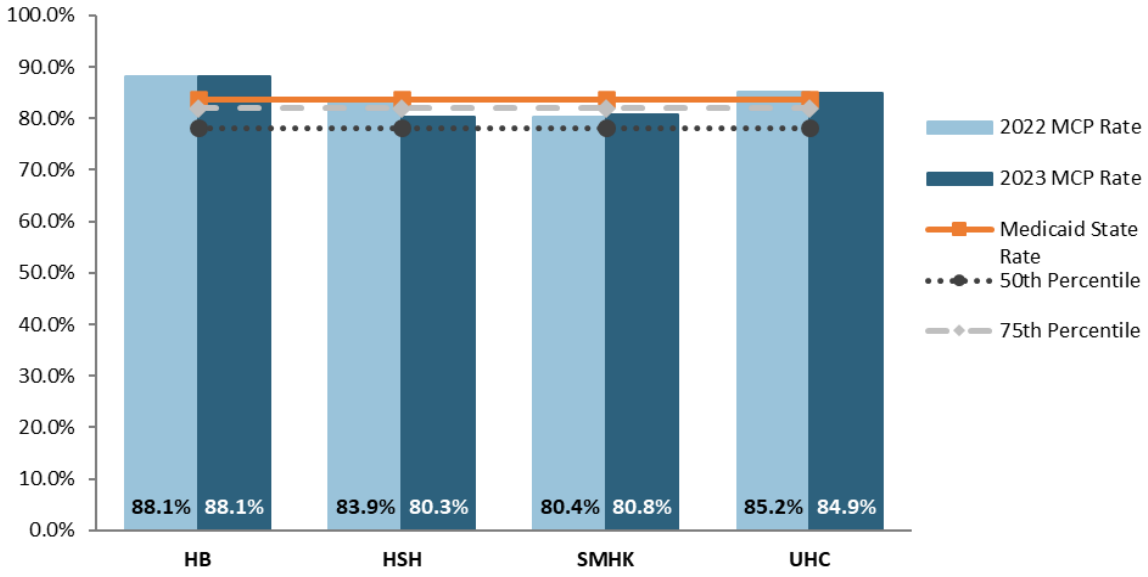
Timeliness of Prenatal Care (PPC)

Figure 15 displays the results for *Timeliness of Prenatal Care (PPC)*. This measure is the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

Results for the measure indicated strengths in related practices.

Analysis indicated no statistically significant change in the Medicaid State Rate between MY2022 and MY2023 and that any change in rates is likely due to normal variation or chance.

Figure 15. Timeliness of Prenatal Care (PPC).



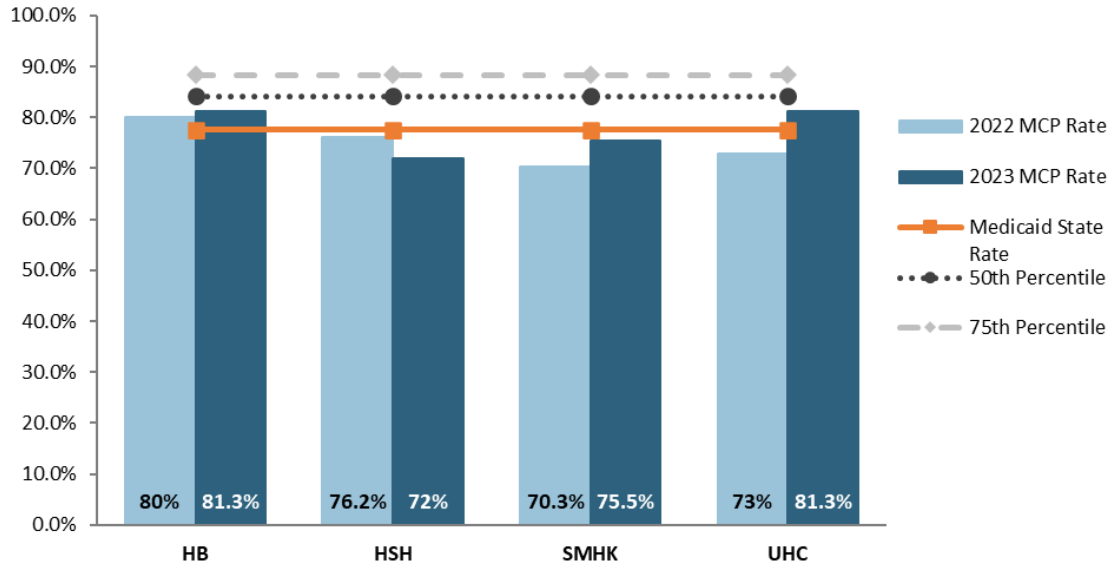
Postpartum Care (PPC)

Figure 16 displays the results for *Postpartum Care (PPC)*. This measure is the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated no statistically significant change in the Medicaid State Rate between MY2022 and MY2023 and that any change in rates is likely due to normal variation or chance.

Figure 16. Postpartum Care (PPC).



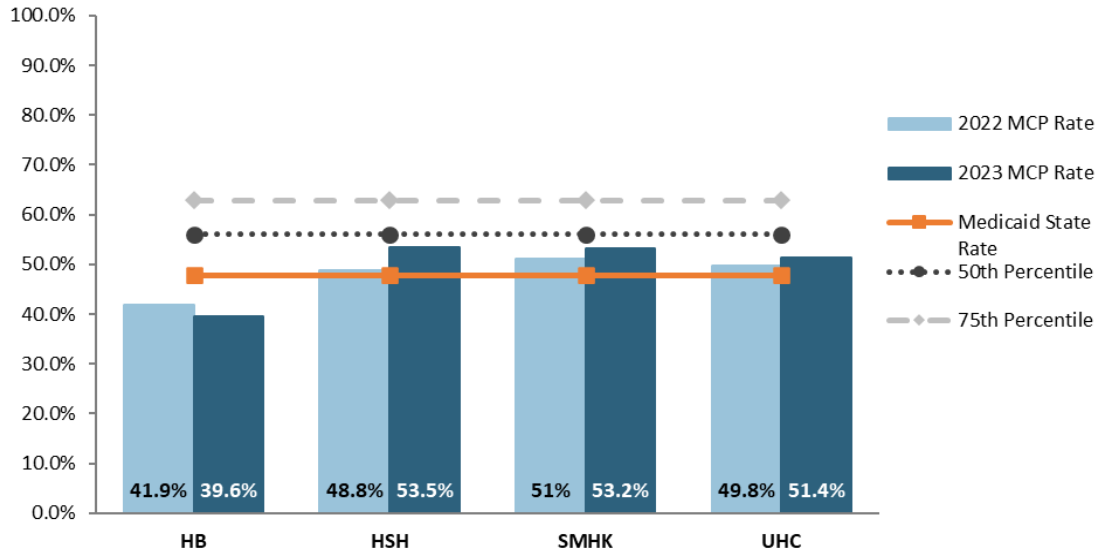
Chlamydia Screening in Women (Total) (CHL)

Figure 17 displays the results for *Chlamydia Screening in Women (Total) (CHL)*. This measure is the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 17. Chlamydia Screening in Women (Total) (CHL).



Improve Management of Behavioral Health & Substance Use Disorder

Improving the management of behavioral health and substance use disorders involves comprehensive strategies to enhance care, support and outcomes for individuals facing mental health conditions and substance-related challenges. The measure for timely follow-up after hospitalization for mental illness ensures that enrollees who have been hospitalized due to a mental health issue receive adequate follow-up in an outpatient setting. This measure reflects timeliness, access and quality.

The results for the FUH 30-day measure reported by the MCPs in MY2022 and MY2023 are compared to the Medicaid State Rate and national benchmarks of the 50th percentile and 75th percentile. Year-to-year results were analyzed for significant change using statistical testing. The results for each measure are summarized below.

Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles. Please refer to the scoring legend below.

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 74.9th and 50th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

Table 41 shows the statistically significant rate change legend for Table 42.

Table 41. Statistically Significant Rate Change Legend.

Statistically Significant Rate Change	Symbols
Increased	▲
Decreased	▼

Table 42. Improve Management of Behavioral Health & Substance Use Disorder Rate MCP Results.

Measure	MY2022 Medicaid State Rate	MY2023 Medicaid State Rate	50th Percentile	75th Percentile	HB*	HSH*	SMHK*	UHC*
Follow-Up After Hospitalization for Mental Illness (FUH 30-day)	44.7%	54%▲	54.9%	64.3%	52.3%▼	51.2%	74.3%▲	45.4%

**MCP results are for MY2023.*

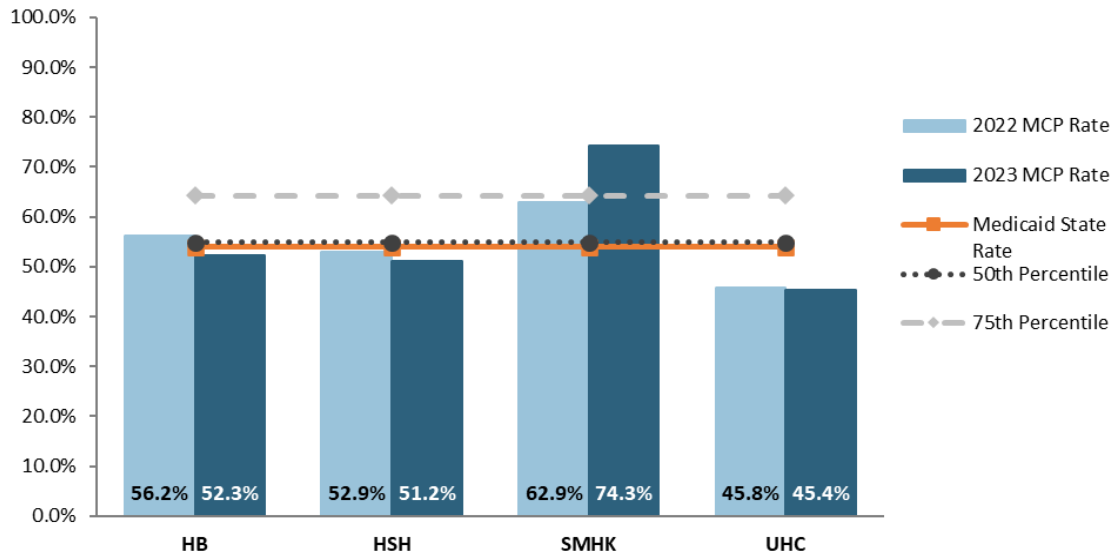
Follow-Up After Hospitalization for Mental Illness (FUH 30-day)

Figure 18 displays the results for *Follow-Up After Hospitalization for Mental Illness (FUH 30-day)*. This measure is the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge.

Results for the measure indicated opportunities for improvement in related practices.

Analysis indicated a statistically significant increase in the Medicaid State Rate between MY2022 and MY2023 and is likely attributable to actions of the MCPs and is unlikely to be the result of normal variation or chance.

Figure 18. Follow-Up After Hospitalization for Mental Illness (FUH 30-day).



Program Level EQRO PMV Recommendation(s)

Based on the program level findings from the PMV review, the following recommendations are provided to MHD for improving measure results. Recommendations were given for those measure rates below the 50th percentile.

MHD should work with the MCPs to:

- Identify and continue the improvement efforts that are driving significant improvement in most of the Well-Child Visits in First 30 Months of Life (W30) and Child & Adolescent Well-Care Visits (WCV) measures.
- Identify and continue the improvement efforts that are driving significant improvement in the following measures:
    - Annual Dental Visits (Total) (ADV)
    - Asthma Medication Ratio (Total) (AMR)
    - Lead Screening in Children (LSC)
    - Follow-Up After Hospitalization for Mental Illness (FUH 30-day)
    - Chlamydia Screening in Women (Total) (CHL)

- Conduct a root cause analysis to identify barriers to improving the following measures:
    - Childhood Immunization Status (Combo 10) (CIS) and Immunizations for Adolescents (Combo 1) (IMA)
    - Postpartum Care (PPC)

Progress on Previous Year (2023) Program Level EQRO Recommendation(s)

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Summary of Plan Level PMV Findings

The following tables (43-46) provide an overview of each MCP's findings. Strengths were given for those measure rates at or above the 75th percentile, while recommendations were given for those measure rates at or below the 50th percentile.

For more detailed information on the findings, please refer to the individual MCP 2024 EQR performance measure validation reports.

Healthy Blue

Table 43. HB PMV Findings.

HB PMV Findings
Strengths
• Timeliness of Prenatal Care (PPC).
Recommendations Based on Weaknesses/Opportunities for Improvement

• Identify and continue the improvement efforts that are driving significant improvement in most of the Well-Child Visits in First 30 Months of Life (W30) and Child & Adolescent Well-Care Visits (WCV) measures
• Identify and continue the improvement efforts that are driving significant improvement in the following measures:
  ○ Annual Dental Visits (Total) (ADV)
  ○ Asthma Medication Ratio (Total) (AMR)
• Conduct a root cause analysis to identify barriers to improving the following measures:
  ○ Childhood Immunization Status (Combo 10) (CIS)
  ○ Immunizations for Adolescents (Combo 1) (IMA)
  ○ Lead Screening in Children (LSC)
  ○ Postpartum Care (PPC)
• Conduct a root cause analysis to identify the factors impacting the decrease in the following measures:
  ○ Chlamydia Screening in Women (Total) (CHL)
  ○ Follow-Up After Hospitalization for Mental Illness (FUH 30-day)

Home State Health

Table 44. HSH PMV Findings.

HSH PMV Findings
Strengths
• No strengths were identified in this year's review.
Recommendations Based on Weaknesses/Opportunities for Improvement

• Identify and continue the improvement efforts that are driving significant improvement in most of the Well-Child Visits in First 30 Months of Life (W30) and Child & Adolescent Well-Care Visits (WCV) measures
• Identify and continue the improvement efforts that are driving significant improvement in the following measures:
  ○ Annual Dental Visits (Total) (ADV)
  ○ Asthma Medication Ratio (Total) (AMR)
  ○ Follow-Up After Hospitalization for Mental Illness (FUH 30-day)
  ○ Lead Screening in Children (LSC)
  ○ Chlamydia Screening in Women (Total) (CHL)
• Conduct a root cause analysis to identify barriers to improving the following measures:
  ○ Childhood Immunization Status (Combo 10) (CIS)
  ○ Immunizations for Adolescents (Combo 1) (IMA)
  ○ Postpartum Care (PPC)
• Conduct a root cause analysis to identify the factors impacting the decrease in the Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD) measure

Show Me Healthy Kids

Table 45. SMHK PMV Findings.

SMHK PMV Findings
Strengths
• Follow-Up After Hospitalization for Mental Illness (FUH 30-day) • Well-Child Visits in First 30 Months of Life (0-15 Months) (W30) • Well-Child Visits in First 30 Months of Life (15-30 Months) (W30)
Recommendations Based on Weaknesses/Opportunities for Improvement

• Conduct a root cause analysis to identify barriers to improving the following measures:
  ○ Child and Adolescent Well-Care Visits (18-21 Years) (WCV)
  ○ Chlamydia Screening in Women (Total) (CHL)
  ○ Comprehensive Diabetes Care (Adequate HbA1c Control) (HBD)
  ○ Postpartum Care (PPC)
• Conduct a root cause analysis to identify the factors impacting the decreases in the following measures:
  ○ Childhood Immunization Status (Combo 10) (CIS)
  ○ Immunizations for Adolescents (Combo 1) (IMA)

UnitedHealthcare

Table 46. UHC PMV Findings.

UHC PMV Findings
Strengths
• Timeliness of Prenatal Care (PPC)
Recommendations Based on Weaknesses/Opportunities for Improvement

• Identify and continue the improvement efforts that are driving significant improvement in most of the Well-Child Visits in First 30 Months of Life (W30) and Child & Adolescent Well-Care Visits (WCV) measures
• Identify and continue the improvement efforts that are driving significant improvement in the following measures:
  ○ Annual Dental Visits (Total) (ADV)
  ○ Asthma Medication Ratio (Total) (AMR)
  ○ Chlamydia Screening in Women (Total) (CHL)
  ○ Postpartum Care (PPC)
• Conduct a root cause analysis to identify barriers to improving the following measures:
  ○ Childhood Immunization Status (Combo 10) (CIS)
  ○ Follow-Up After Hospitalization for Mental Illness (FUH 30-day)
  ○ Immunizations for Adolescents (Combo 1) (IMA)
  ○ Lead Screening in Children (LSC)

Progress on Previous Year (2023) Plan Level EQRO Recommendations

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Compliance with Standards Review

Objective

The purpose of the compliance review is to determine whether Medicaid managed care plans are following federal standards. CMS developed mandatory standards for MCPs which are codified at 42 CFR 438[12] and 42 CFR 457[13], as revised by the Medicaid and CHIP managed care final rule issued in 2016. For this mandatory EQR activity, MetaStar, under contract with Comagine Health, completed the compliance review.

Overview

Federal regulations require MCPs to have undergone a review within the three-year period preceding each annual EQR to determine MCP compliance with federal standards as implemented by the state.

MHD and Comagine Health have chosen to spread the review over a three-year cycle as shown in Table 47. CHIP citations are included in this table for informational purposes. The citations for the managed care rule will be used throughout the report. Note: these standards fall under the domains of quality, access and timeliness of health care and services.

Table 47. Compliance with Principal Standards Reviewed in the Current Cycle (2024-2027).

42 CFR 438 (Managed Care)	42 CFR 457 (CHIP)	Standard Name	Year 1	Year 2	Year 3
§438.56	§457.1212	Disenrollment: Requirements and limitations	X	–	–
§438.100	§457.1220	Enrollee rights and protections	X	–	–
§438.114	§457.1228	Emergency and post-stabilization services	X	–	–
§438.206	§457.1230(a)	Availability of services	X	–	–
§438.207	§457.1230(b)	Assurances of adequate capacity and services	X	–	–
§438.208	§457.1230(c)	Coordination and continuity of care	X	–	–
§438.210	§457.1230(d)	Coverage and authorization of services	X	–	–
§438.214	§457.1233(a)	Provider selection	X	–	–
§438.224	§457.1230(c)	Confidentiality	X	–	–
§438.230	§457.1233(b)	Subcontractual relationships and delegation	X	–	–
§438.236	§457.1233(c)	Practice guidelines	X	–	–
§438.242	§457.1233(d)	Health information systems	X	–	–
§438.228	§457.1260	Grievance and appeal systems	–	X	–
§438.330	§457.1240(b)	Quality assessment and performance improvement program	–	–	X

[12] Electronic Code of Federal Regulations. Title 42, part 438 – Managed Care. Available at: https://www.ecfr.gov/current/title-42/part-438.

[13] Electronic Code of Federal Regulations. Title 42, part 457 Allotments and Grants to States. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=60f9f0f14136be95a1cee250074ae00d&mc=true&node=pt42.4.457&rgn=div5.

Methodology

The compliance review, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted during March - June 2024, using the review period of CY2023. The review followed the guidelines from CMS, *EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations.*

Scoring

Each standard has a specified number of scoring elements, which correlate with federal standards and MHD contract requirements. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with a compliance rating that aligns with Protocol 3.

For a full description of the methodology, including technical methods of data collection, description of data obtained and how the data was aggregated and analyzed, please see Appendix C: Compliance with Standards Methodology.

Summary of Compliance Results

Table 48 shows the scoring key for compliance as expressed in terms of a percentage score and compliance rating.

Table 48. Compliance Rating Legend.

Score	Compliance Rating
90% - 100%	Fully Met
80% - 89.9%	Substantially Met
70% - 79.9%	Partially Met
60% - 69.9%	Minimally Met
≤ 59.9%	Not Met

Table 49 summarizes all MCPs and provides an aggregate overview (MO) of their results of compliance at the program level for Year 1 of the current three-year cycle. Plans with elements scored as Partially Met or Not Met were required to submit CAPs to Comagine Health. Plans were scored on these elements in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, scores may not be indicative of current performance.

Table 49. Individual MCP Compliance and Program Level Results.

Std.	42 CFR Citation	HB	HSH	SMHK	UHC	MO*
M1	Availability of services – §438.206	100%	100%	100%	100%	100%
M2	Furnishing of services and timely access – §438.206(c)(1)	100%	100%	100%	100%	100%
M3	Access and cultural considerations in services – §438.206(c)(2)	100%	100%	100%	100%	100%
M4	Assurances of adequate capacity and services – §438.207**	NA	NA	NA	NA	NA

Std.	42 CFR Citation	HB	HSH	SMHK	UHC	MO*
M5	Coordination and continuity of care, and confidentiality – §§438.208, 438.224	90.9%	100%	100%	90.9%	96%
M6	Additional coordination and continuity of care requirements – §438.208(c)	50%	100%	100%	50%	81.8%
M7	Disenrollment: requirements and limitations - §438.56	100%	100%	100%	100%	100%
M8	Coverage and authorization of services – §§438.210, 440.230, 438.441 Emergency and post-stabilization services – §438.114	100%	100%	100%	100%	100%
M9	Information requirements for all enrollees – §§438.100(b)(2)(i), 438.10	72.7%	90.9%	90.9%	72.7%	81.8%
M10	Enrollee right to receive information on available provider options – §§438.100(b)(2)(iii), 438.102	66.7%	66.7%	66.7%	100%	75%
M11	Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint – §§438.100(b)(2)(iv) and (v), 438.3(j)	100%	60%	50%	100%	76.2%
M12	Compliance with other federal and state laws – §438.100(d)	0%	100%	100%	100%	75%
M13	Provider selection – §438.214	100%	77.8%	77.8%	88.9%	86.1%
M14	Subcontractual relationships and delegation – §438.230	100%	100%	100%	100%	100%
M15	Practice guidelines – §438.236	80%	80%	80%	100%	85%
M16	Health information systems – §438.242**	NA	NA	NA	NA	NA

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores.*

***M4 is evaluated as part of the MCP's Network Adequacy Validation conducted annually. M16 is evaluated as part of the MCP's ISCA conducted once every three years. The Network Adequacy Validation and the ISCA occur separate from the compliance with standards review.*

Program Level Compliance EQRO Recommendation(s)

Based on the program level findings from the compliance with standards review, weaknesses or opportunities for improvement were identified for any standard that is below 90% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements. MCP specific recommendations are provided in the individual MCP 2024 EQR compliance with standards reports.

- Additional coordination and continuity of care requirements (81.8%) **(M6)**
  - Two of the four MCPs scored 50% on this standard.
- Information requirements for all enrollees (81.8%) **(M9)**
  - Two of the four MCPs scored 72.7%% on this standard.
- Enrollee right to receive information on available provider options (75%) **(M10)**
  - Three of the four MCPs received a score of 66.7% on this standard.
- Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint (76.2%) **(M11)**

  - Two of the four MCPs received a score of 60% or below on this standard.
- Compliance with other federal and state laws (75%) **(M12)**
  - One of the four MCPs received a score of 0% on this standard.
- Provider selection (86.1%) **(M13)**
  - Three of the four MCPs scored below 90% on this standard.
- Practice Guidelines (85%) **(M15)**
  - Three of the four MCPs received a score of 80% on this standard.

Progress on Previous Year (2023) Program Level Compliance EQRO Recommendation(s)

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Summary of Plan Level Compliance Findings

Based on the plan level findings from the compliance with standards review, strengths were identified for any standard that scored at or above 90%. Weaknesses or opportunities for improvement were identified for any standard that is below 90% and are presented as a recommendation.

MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance. An update of the current year's EQRO recommendations will be reflected in the 2025 Annual Technical Report.

The following provides an overview of the individual compliance findings for the MCPs. For more detailed information on the findings, please refer to the individual MCP's 2024 EQR compliance with standards report.

Healthy Blue

The following tables describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for HB.

Table 50. HB: Strengths.

Strengths
• HB maintained and monitored a network of appropriate providers, which was sufficient to provide adequate access to all services under the contract. The information was provided to members through a provider directory maintained by HB **(M1)**. • The provider file verification confirmed HB has an up-to-date searchable provider directory available on its website **(M1)**. • HB required its providers to meet state standards ensuring timely access to care and services **(M2).** • HB participated in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic background, disabilities and regardless of sex **(M3)**.

Strengths
• HB implemented procedures to deliver care to and coordinate services for all MCP members **(M5)**. • The interviews with HB staff identified a number of different resources available to support CM staff in their roles, including supervisor support, staff meetings, regular interdisciplinary rounding meetings for case consultations and problem solving, and a number of different trainings to build skills sets **(M5)**. • HB complied with requirements for member disenrollment **(M7)**. • HB's policies and procedures for service authorizations complied with required standards **(M8)**. • The provider file verification confirmed HB has an up-to-date searchable provider directory available on its website which includes detailed requirements related to the provider type, location, contact information, cultural and linguistic capabilities, whether the provider is accepting new patients and accommodations for people with physical disabilities **(M9)**. • HB had written policies and procedures in place for member rights and advance directives, which included the right to participate in decisions regarding his or her care, the right to be free from any form of restraint and the right to refuse treatment **(M11)**. • HB had a written process for the selection and periodic evaluation of qualified providers. The health plan was responsible for ensuring all applicable provider requirements were met at initial contracting and throughout the duration of the provider's contract **(M13).** • The provider file verification confirmed HB adheres to its written credentialing and recredentialing policies and procedures by ensuring in-network providers are licensed by the state in which the provider practices, are credentialed and recredentialed and have not been convicted of criminal activity or excluded from participation in Medicare, Medicaid, CHIP or any federal health care program **(M13)**. • HB oversaw and was accountable for functions and responsibilities that it delegated to subcontractors/providers. HB monitored the subcontractor's/provider's performance, and took corrective action as needed **(M14)**. • The provider file verification confirmed HB has written subcontracts with providers detailing the scope of services provided and contract expectations and investigates and responds to issues involving subcontractors **(M14)**.

Table 51. HB: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, HB should:
Recommendations Based on Weaknesses/Opportunities for Improvement • Develop and implement a method to monitor initial screening timeframes for new enrollees and evaluate the data for compliance with requirements **(M5)**. • Develop and implement a method to aggregate the MCP's internal CM results from the auditing processes, specifically for the assessment timeframes, and evaluate the data for compliance with requirements **(M6)**. • Update the Member Materials – Appropriateness Policy document to include the specific requirements related to the provision of marketing and member education information in electronic format, as outlined in 42 CFR §438.10 **(M9)**.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, HB should:
• Develop and implement a policy and procedure that includes the additional requirements for in-network PCP moves. Ensure that staff are trained on these requirements **(M9)**. • Develop and implement a policy and procedure detailing the methods used by the organization to disclose information to members regarding the use of a physician incentive plan, the type of plan used, and whether stop-loss insurance is provided. Ensure that staff are trained on where to find this information so that it can be provided when requested **(M9)**. • Develop and implement a policy and procedure that includes the process for notifying the state agency, as well as potential members, if any ethical objections to required services arise. It is further recommended to include in member materials the information that the MCP does not currently have any moral or religious objections to any services the organization is required to provide or reimburse **(M10)**. • Develop and implement a policy and procedure that includes all federal nondiscrimination laws as well as all Missouri state specific regulations and executive orders that are required by the contract for both members and employees of HB **(M12)**. • Ensure website links used to disseminate clinical practice guideline to providers are functional **(M12)**.

Home State Health

The following tables describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for HSH.

Table 52. HSH: Strengths.

Strengths
• HSH maintained and monitored a network of appropriate providers, which was sufficient to provide adequate access to all services under the contract. The information was provided to members through a provider directory maintained by HSH **(M1)**. • The provider file verification confirmed HSH has an up-to-date searchable provider directory available on its website **(M1)**. • HSH required its providers to meet state standards ensuring timely access to care and services **(M2)**. • HSH participated in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic background, disabilities and regardless of sex **(M3)**. • HSH implemented procedures to deliver care to and coordinate services for all MCP members **(M5)**. • HSH demonstrated comprehensive CM programs, which emphasized the importance of member experiences and outcomes. Detailed information on roles and responsibilities and staff qualifications were included. The interviews highlighted a number of resources and supports available to care managers, including a SharePoint site to easily look up policies and procedures and other job-related topics, supervisor support and a comprehensive training plan to aid in onboarding new staff, as well as ample opportunity for ongoing education **(M5)**.

Strengths
• HSH implemented mechanisms to comprehensively assess each Medicaid enrollee identified by the state, and identified to HSH by the state, as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring **(M6)**. • In addition to the information and staff resources shared in scoring element **M5** above, which also support the requirements for scoring standard **M6**, the MCP demonstrated monitoring of CM practices through the use of a dashboard to track timeliness of assessments and other requirements, as well as a comprehensive audit tool to monitor the requirements of CM practices. The audit tool results are shared at the individual CM level, as well as aggregated to identify program level findings, trends and gaps **(M6)**. • HSH complied with requirements for member disenrollment **(M7)**. • HSH's policies and procedures for service authorizations complied with required standards **(M8)**. • HSH provided readily accessible written information to members in a manner and format that was easily understood **(M9)**. • The provider file verification confirmed HSH has an up-to-date searchable provider directory available on its website which includes detailed requirements related to the provider type, location, contact information, cultural and linguistic capabilities, whether the provider is accepting new patients and accommodations for people with physical disabilities **(M9)**. • HSH complied with all applicable federal and state laws for the protection of member rights **(M12)**. • HSH oversaw and was accountable for functions and responsibilities that it delegated to any subcontractor/provider. HSH monitored the subcontractor/provider's performance and took corrective action as needed **(M14)**. • The provider file verification confirmed HSH has written subcontracts with providers detailing the scope of services provided and contract expectations and investigates and responds to issues involving subcontractors **(M14)**.

Table 53. HSH: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, HSH should:
• Amend or create an internal policy or procedure document directed towards HSH staff. This document should include members' rights to receive information on available treatment options and alternatives, as well as outline how this information is appropriately conveyed to members **(M10)**. • Amend or create an internal written policy and/or procedure document that includes specific member rights, how these rights are safeguarded, as well as how staff and in-network providers take these rights into account when furnishing services to members **(M11)**. • Amend or create an internal written policy and/or procedure document that includes specific member rights, how these rights are safeguarded, and how staff and in-network providers take these rights into account when furnishing services to members **(M11)**. • Update policies and procedures to reflect practices related to a simplified and expedited credentialing process for providers who are currently credentialed by another plan administered by the health plan or its affiliates and who are enrolled as a Missouri Medicaid Provider with

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, HSH should:
Missouri Medicaid Audit Compliance **(M13)**. • Conduct audits of primary care providers, hospitals, home health agencies, personal care providers and hospices to determine whether the provider is following the policies and procedures related to advance directives **(M13)**. • Ensure credentialing and re-credentialing documentation for facilities and organizations includes evidence the health plan screens all health care service subcontractors to determine whether the subcontractor or any of its employees have been excluded from participation in Medicare, Medicaid, CHIP or any federal health care program **(M13)**. • Ensure website links used to disseminate clinical practice guidelines to providers and members are functional **(M15)**.

Show Me Healthy Kids

The following tables describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for SMHK.

Table 54. SMHK: Strengths.

Strengths
• SMHK maintained and monitored a network of appropriate providers, which was sufficient to provide adequate access to all services under the contract. The information was provided to members through a provider directory maintained by SMHK**.** • The provider file verification confirmed SMHK has an up-to-date searchable provider directory available on its website **(M1)**. • SMHK required its providers to meet state standards ensuring timely access to care and services **(M2)**. • SMHK participated in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic background, disabilities and regardless of sex **(M3)**. • SMHK implemented procedures to deliver care to and coordinate services for all MCP members **(M5)**. • SMHK demonstrated comprehensive CM programs, which emphasized the importance of member experiences and outcomes. Detailed information on roles and responsibilities and staff qualifications were included. The interviews highlighted a number of resources and supports available to care managers, including a SharePoint site to easily look up policies and procedures and other job-related topics, supervisor support and a comprehensive training plan to aid in onboarding new staff, as well as ample opportunity for ongoing education **(M5)**. • SMHK implemented mechanisms to comprehensively assess each Medicaid enrollee identified by the state, and identified to SMHK by the state, as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. • In addition to the information and staff resources shared in scoring element **M5** above, which also support the requirements for scoring standard **M6**, the MCP demonstrated monitoring of CM practices through the use of a dashboard to track timeliness of assessments and other

Strengths
requirements, as well as a comprehensive audit tool to monitor the requirements of CM practices. The audit tool results are shared at the individual CM level, as well as aggregated to identify program level findings, trends and gaps **(M6)**. • SMHK complied with requirements for member disenrollment **(M7)**. • SMHK's policies and procedures for service authorizations complied with required standards **(M8)**. • SMHK provided readily accessible written information to members in a manner and format that was easily understood **(M9)**. • The provider file verification confirmed SMHK has an up-to-date searchable provider directory available on its website which includes detailed requirements related to the provider type, location, contact information, cultural and linguistic capabilities, whether the provider is accepting new patients and accommodations for people with physical disabilities **(M9)**. • SMHK complied with all applicable federal and state laws for the protection of member rights **(M12)**. • SMHK oversaw and was accountable for functions and responsibilities that it delegated to any subcontractor/provider. SMHK monitored the subcontractor/provider's performance and took corrective action as needed **(M14)**. • The provider file verification confirmed SMHK has written subcontracts with providers detailing the scope of services provided and contract expectations and investigates and responds to issues involving subcontractors **(M14)**.

Table 55. SMHK: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, SMHK should:
• Amend or create an internal policy or procedure document directed towards SMHK staff. This document should include members' rights to receive information on available treatment options and alternatives, as well as outline how this information is appropriately conveyed to members **(M10)**. • Amend or create an internal written policy and/or procedure document that includes specific member rights, how these rights are safeguarded, as well as how staff and in-network providers take these rights into account when furnishing services to members **(M11)**. • The missing policy and/or procedure requirements regarding advance directive information being provided to transition aged youth, adult specialty plan members and their parents/guardians has already been remediated. It is recommended that this policy be further updated to include references to compliance with Section 404.800 Missouri Revisor of Statutes (RSMo), and the Durable Power of Attorney for Health Care Act. **(M11)**. • Update policies and procedures to reflect practices related to a simplified and expedited credentialing process for providers who are currently credentialed by another plan administered by the health plan or its affiliates and who are enrolled as a MMAC **(M13)**. • Conduct audits of primary care providers, hospitals, home health agencies, personal care providers and hospices to determine whether the provider is following the policies and procedures related to advance directives **(M13)**. • Ensure credentialing and re-credentialing documentation for facilities and organizations includes

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, SMHK should:
evidence the health plan screens all health care service subcontractors to determine whether the subcontractor or any of its employees have been excluded from participation in Medicare, Medicaid, CHIP or any federal health care program **(M13)**. • Ensure website links used to disseminate clinical practice guidelines to providers and members are functional **(M15)**.

United Healthcare

The following tables describes the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for UHC.

Table 56. UHC: Strengths.

Strengths
• UHC maintained and monitored a network of appropriate providers, which was sufficient to provide adequate access to all services under the contract. The information was provided to members through a provider directory maintained by UHC. • The provider file verification confirmed UHC has an up-to-date searchable provider directory available on its website **(M1)**. • UHC required its providers to meet state standards ensuring timely access to care and services **(M2)**. • UHC participated in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic background, disabilities and regardless of sex **(M3)**. • UHC implemented procedures to deliver care to and coordinate services for all MCP members **(M5)**. • The interviews with MCP staff indicated a variety of trainings and resources available to care managers to support them in their roles, including weekly interdisciplinary "rounding" meetings for case consultations and problem solving on challenging situations **(M5)**. • UHC complied with requirements for member disenrollment **(M7)**. • UHC's policies and procedures for service authorizations complied with the required standards **(M8)**. • UHC ensured members received information on available provider options. Additionally, UHC did not restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member **(M10)**. • UHC had written policies and procedures in place for member rights and advance directives, which included the right to participate in decisions regarding his or her care, the right to be free from any form of restraint and the right to refuse treatment **(M11)**. • UHC complied with all applicable federal and state laws for the protection of member rights **(M12)**. • The provider file verification confirmed UHC adheres to its written credentialing and recredentialing policies and procedures by ensuring in-network providers are licensed by the state in which the provider practices, are credentialed and recredentialed and have not been

Strengths
convicted of criminal activity or excluded from participation in Medicare, Medicaid, CHIP or any federal health care program **(M13)**. • UHC oversaw and was accountable for functions and responsibilities that it delegated to any subcontractor/provider. UHC monitored the subcontractor/provider's performance, and took corrective action as needed **(M14)**. • The provider file verification confirmed UHC has written subcontracts with providers detailing the scope of services provided and contract expectations and investigates and responds to issues involving subcontractors **(M14)**. • UHC adopted, applied and disseminated practice guidelines based on the needs of its members **(M15)**.

Table 57. UHC: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, UHC should:
• Develop and implement a method to aggregate the results from the auditing process, specifically for the initial screening timeframes for new enrollees, and evaluate the data for compliance with requirements **(M5)**. • Develop and implement a method to aggregate the results from the auditing process, specifically for the assessment timeframes, and evaluate the data for compliance with requirements **(M6)**. • Update the *Marketing Guidelines Policy and Procedure* document to include the specific requirements outlined in 42 CFR 438.10 **(M9)**. • Ensure that annual notification to members of their disenrollment rights includes specific reasons for disenrollment with or without cause and the alternatives available to the enrollee based on their specific circumstance **(M9)**. • Develop and implement a policy and procedure detailing the methods used by the organization to disclose information to members regarding the use of a physician incentive plan, the type of plan used and whether stop-loss insurance is provided. Ensure that staff are trained on where to find this information so that it can be provided when requested **(M9)**. • UHC should develop and implement a process to ensure that printed directories are available and can be mailed within 48 hours of a member request **(M9)**. • Ensure provider contracts are terminated when a provider fails to comply with recredentialing requirements, and the provider is deleted from the provider directory **(M13)**.

Progress on Previous Year (2023) EQRO Plan Level Recommendation(s)

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Network Adequacy Validation

Objective

The purpose of network adequacy validation (NAV) is to determine the extent to which Medicaid and CHIP MCPs comply with network adequacy requirements during the preceding 12 months set forth in 42 CFR §438.68.

States are required to ensure that CHIPs and MCPs have provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across all services. According to 42 CFR §438.68, states must establish measurable network adequacy standards for MCPs that consider regional factors and the needs of their Medicaid and CHIP populations. In addition, if the state enrolls American Indians and Alaska Natives in the MCP, it must comply with 42 CFR §438.14(b)(1). State-defined network adequacy standards must be included in the state's quality strategy per 42 CFR §340(b)(1).

Overview

MHD developed the following time and travel distance standards that align managed care network adequacy reviews with federal requirements per 42 CFR §§438.68, 438.206, 438.358(b)(1)(iv), 457.1218 and 457.1230. Comagine Health conducted validation of network adequacy according to the MHD defined network standards.

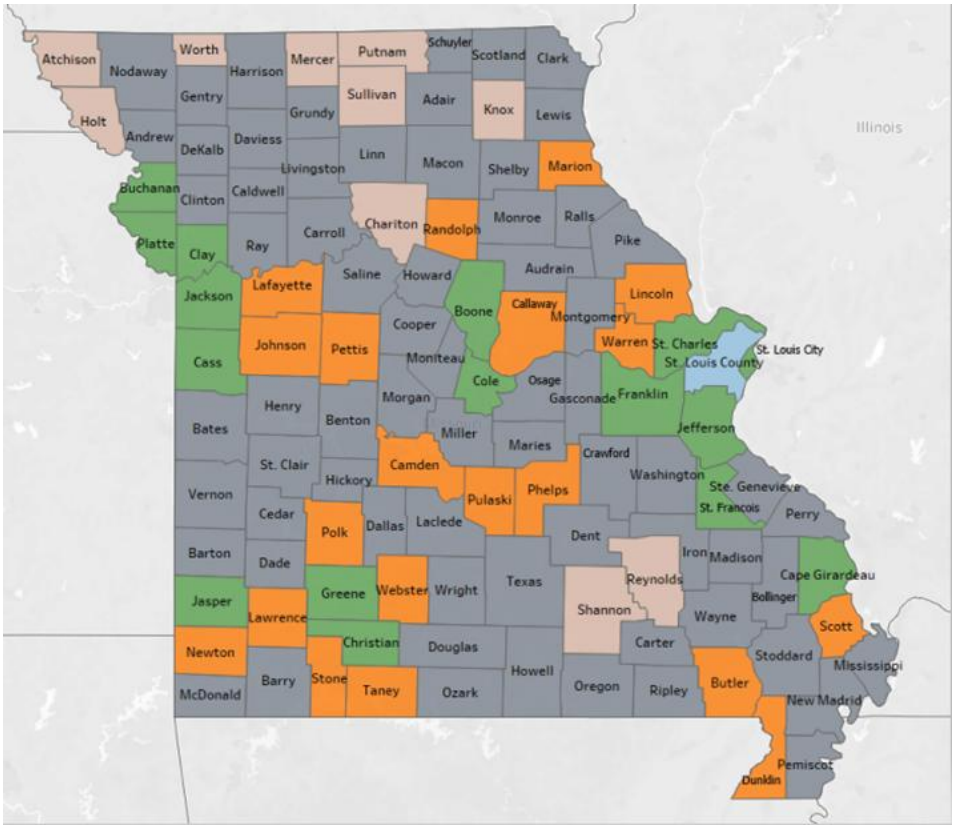
The MHD defined standard is for 100% of enrollees to have access to a provider within the applicable travel time or distance in all categories. Any score of 99.5% and above will be rounded up to 100%. Percent of access is determined by meeting either time or distance standards. Note: these standards fall under the domains of access and timeliness of health care and services.

Geographically, Missouri is made up of 115 counties, including St. Louis City. Based on population and density, approximately 70% of Missouri counties are classified as rural or counties with extreme access considerations (CEAC). Therefore, MHD has chosen to apply the county designations of large metro, metro, micro, rural and CEAC[14] to each county as shown in the following figure.

Figure 19 shows a map of the county designations for the state of Missouri.

[14] Missouri Department of Social Services. Provider Network Adequacy Standards. Published January 2024, revised July 2024. Available at: https://mydss.mo.gov/media/pdf/provider-network-adequacy-standards.

Figure 19. Map of County Designations.



Provider Network Adequacy Standards

The following tables (Tables 58-63) describe MHD's 2024 network adequacy standards by provider type and specialty for both adult and pediatric services, including the county type designation and county classification (Large Metro, Metro, Micro, Rural and CEAC).[15] Pediatric standards apply to members enrolled in managed care ages 0 through 20 years old.

Table 58. Provider Type: Primary Care – Adult & Pediatric.

Standard: 100% of MCP enrollees must have access to two providers within specified time or distance standards.

Provider Type	Large Metro, Metro, Micro	Rural, CEAC
Adult Primary Care Providers (PCPs)	15 miles or 20 minutes	30 miles or 45 minutes
Pediatric Primary Care Providers (PCPs)	15 miles or 20 minutes	30 miles or 45 minutes

[15] Missouri Department of Social Services. Provider Network Adequacy Standards. Published January 2024, revised July 2024. Available at: https://mydss.mo.gov/media/pdf/provider-network-adequacy-standards.

Table 59. Provider Type: Dental — Adult & Pediatric.

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type	Large Metro, Metro, Micro	Rural, CEAC
Dental	25 miles or 40 minutes	40 miles or 55 minutes
Pediatric Dental	25 miles or 40 minutes	40 miles or 55 minutes

Table 60. Provider Type: Ancillary & Facility Provider Types.

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type	Large Metro, Metro, Micro	Rural, CEAC
Hospital	30 miles or 45 minutes	40 miles or 55 minutes
Audiology	30 miles or 45 minutes	60 miles or 75 minutes
Occupational Therapy	30 miles or 45 minutes	60 miles or 75 minutes
Physical Therapy	30 miles or 45 minutes	60 miles or 75 minutes
Speech Therapy	30 miles or 45 minutes	60 miles or 75 minutes
Inpatient Mental Health	40 miles or 55 minutes	75 miles or 90 minutes
Ambulatory Mental Health	30 miles or 45 minutes	60 miles or 75 minutes

Table 61. Provider Type: OB/GYN.

Standard: 100% of MCP enrollees must have access to two providers within specified time or distance standards.

Provider Type	Large Metro, Metro	Micro	Rural, CEAC
OB/GYN	20 miles or 30 minutes	40 miles or 55 minutes	60 miles or 75 minutes

Table 62. Provider Type: Behavioral Health — Adult & Pediatric.

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type	Large Metro	Metro	Micro	Rural	CEAC
Mental Health & SUD – Adult	10 miles or 15 minutes	20 miles or 30 minutes	30 miles or 45 minutes	40 miles or 55 minutes	50 miles or 65 minutes
Mental Health & SUD – Pediatric	10 miles or 15 minutes	20 miles or 30 minutes	30 miles or 45 minutes	40 miles or 55 minutes	50 miles or 65 minutes
Psychiatrist – Adult	20 miles or 30 minutes	40 miles or 55 minutes	60 miles or 75 minutes	80 miles or 100 minutes	90 miles or 120 minutes
Psychiatrist – Child/Adolescent	20 miles or 30 minutes	40 miles or 55 minutes	60 miles or 75 minutes	80 miles or 100 minutes	90 miles or 120 minutes

Table 63. Provider Type: Specialists — Adult & Pediatric.*

Standard: 100% of MCP enrollees must have access to one provider within specified time or distance standards.

Provider Type**	Large Metro	Metro	Micro	Rural	CEAC
Adult & Pediatric Specialists (17 specialties)	25 miles or 40 minutes	50 miles or 65 minutes	75 miles or 90 minutes	90 miles or 120 minutes	110 miles or 145 minutes
Adult & Pediatric Specialists (4 specialties)	15 miles or 20 minutes	35 miles or 50 minutes	45 miles or 60 minutes	60 miles or 75 minutes	80 miles or 100 minutes

**Specialties in this table will be analyzed individually by medical professional code and separated by adult and pediatric populations.*

***See 2024 Provider Network Adequacy Standards for complete list of provider specialties*.

Methodology

To ensure network adequacy, Comagine Health completed a comprehensive validation process for each MCP following the process outlined in *CMS Protocol 4: Validation of Network Adequacy* during the period of May – September 2024.

The validation of network adequacy is based on completing the protocol worksheets, particularly 4.6, which focuses on the Assessment of MCP Network Adequacy Data, Methods, and Results. Additionally, it includes validating network adequacy through data and file submissions from both the MCPs and MHD, along with reports produced by Quest Analytics. Quest Analytics' Quest Enterprise Services (QES) network adequacy analysis software was used to compile and analyze member enrollment and provider network information provided by MHD and the MCPs. Each quarter, MHD provides managed care enrollment files to Quest Analytics and the MCPs submit quarterly provider network files to MHD using specified file formats. The EQR review was based on the third submission of the provider network data files as of July 1, 2024, due the last working day of July 2024.

In addition, the review assessed activity requirements set forth in 42 CFR §438.68 and, if the state enrolls American Indians and Alaska Natives in the MCP, PIHP or PAHP, 42 CFR §438.14(b)(1). The review also evaluated each MCP provider network in relation to MHD's contractual requirements and 2024 Provider Network Adequacy Standards.

Provider Network Access Results

Comagine Health completed a review of the data and methods used to calculate the provider network access indicator results and has high confidence in the provider network access indicator results. The tables below summarize each MCP's provider network access results, along with aggregate results (MO) at the program level, which include the percentage meeting access standards, categorized by provider type and county classification.

Overall, the network adequacy standards review and validation results for the MCPs and MO indicate a very comprehensive provider network.

Summary of Plan Level Provider Network Access Results

Table 64 provides a list of network adequacy indicators that did not meet the state-defined standards by provider specialty type and county classification for the MCPs as well as an aggregate result (MO) at the

program level. All other network adequacy indicators were met at 100%. Any score of 99.5% and above will be rounded up to 100%. For more detailed information on the network access results, please refer to the individual MCP 2024 EQR NAV reports.

Table 64. Summary of Plan Level Provider Network Access Results.

Specialty	County Classification	Standard	HB	HSH/ SMHK	UHC	MO
Ancillary and Facility						
Audiology	Large Metro, Metro, Micro	30 Miles/ 45 Minutes	95.9%	100%	97.2%	97.7%
Inpatient Mental Health	Large Metro, Metro, Micro	40 Miles/ 55 Minutes	99%	100%	100%	100%
Specialists – Adult and Pediatric						
Allergy - Adult	Metro	50 Miles/ 65 Minutes	100%	100%	96%	98.6%
Allergy - Adult	Micro	75 Miles/ 90 Minutes	100%	84.8%	95.2%	93.8%
Allergy - Adult	Rural	90 Miles/ 120 Minutes	100%	96.8%	100%	99%
Allergy - Pediatric	Metro	50 Miles/ 65 Minutes	100%	100%	95.5%	98.7%
Allergy - Pediatric	Micro	75 Miles/ 90 Minutes	100%	84.4%	95.3%	93.1%
Allergy - Pediatric	Rural	90 Miles/ 120 Minutes	100%	96.7%	100%	98.8%
Chiropractic - Adult	Rural	60 Miles/ 75 Minutes	99.4%	97.3%	100%	99%
Chiropractic - Pediatric	Rural	60 Miles/ 75 Minutes	100%	97.1%	100%	98.9%

Network Adequacy Contract Requirements Documentation Review Results

Tables 65-66 provides the results of the review of the documents submitted by the MCPs to demonstrate their compliance with the following network contract requirements.

Table 65. Network Adequacy Contract Requirements Documentation Review Results – HB, HSH and UHC.

Network Adequacy Contract Requirements Documentation Review Results			
Contract Section and Requirement	**HB**	**HSH**	**UHC**
2.5.9 c. Psychiatric Residential Treatment Facilities (hereinafter referred to as PRTFs) – The health plan shall include in the health plan provider network, both state-	Met	Met	Met

Network Adequacy Contract Requirements Documentation Review Results			
Contract Section and Requirement	**HB**	**HSH**	**UHC**
and privately- operated PRTFs that deliver psychiatric residential treatment services to youth with serious emotional disturbance when the youth cannot be treated in an alternative level of care.			
2.5.19 American Indian/Alaskan Natives – The health plan shall ensure that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP) including Indian Health Services, Tribal 638, and Urban Indian provider.	Met	Met	Met

Table 66. Network Adequacy Contract Requirements Documentation Review Results: SMHK Only.

Network Adequacy Contract Requirements Documentation Review Results	SMHK Only
Contract Section and Requirement	**SMHK**
3.4.4 Behavioral Health Providers – In addition to the requirements otherwise specified herein in "Behavioral Health Providers," the Specialty Plan shall also include the following behavioral health service providers in its provider network:	
3.4.4 a. Comprehensive Community Support Services (hereinafter referred to as CCS) Providers – The Specialty Plan shall include providers in network that deliver CCS services for Specialty Plan members placed in a CD-licensed residential facility, qualified residential treatment program (hereinafter referred to as QRTP) as set forth in 13 CSR 35-71.150, therapeutic foster home, or as aftercare following the member's discharge from such placements.	Met
3.4.4 b. Practitioners certified in one or more of the following evidence-based practice: Eye Movement Desensitization Reprocessing, Trauma Focused Cognitive-Behavioral Therapy, and Dialectical Behavior Therapy.	Met

Summary of NAV Results

Comagine Health utilized the worksheets from Protocol 4, Validation of Network Adequacy, to support the review of the MCP's network adequacy. Worksheet 4.6 below was completed to evaluate and assess the data and methods used to calculate results generated for the network adequacy indicators. In addition, these worksheets supported the generation of a validation rating reflecting the overall adequacy.

The worksheet supported the generation of a validation rating that reflects the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis and interpretation of the network adequacy indicator.

Each element in the table below is presented as either "Yes," "No" or "Not Applicable (NA)" based on the validation results. Elements scored "NA" are not included in the final scoring. Standard scores are presented as the number of "Yes" elements out of the total number of scoring elements excluding elements scored as "NA." Table 67 summarizes the overall assessment of MCPs' data, methodology and results.

Table 67. Assessment of the MCP's Network Adequacy Data, Methods and Results.

Question	HB	HSH/ SMHK	UHC
Assessment of data collection procedures			
Were all data sources (and year[s] of data) needed to calculate this indicator submitted by the MCP?	Y	Y	Y
For each data source, were all variables needed to calculate this indicator included?	Y	Y	Y
Are there any patterns in missing data that may affect the calculation of this indicator?	NA	NA	NA
Do the MCP's data enable valid, reliable and timely calculations of this indicator?	Y	Y	Y
Did the MCP's data collection instruments and systems allow for consistent and accurate data collection for this indicator over the time periods studied?	Y	Y	Y
During the time period included in the reporting cycle, have there been any changes in the MCP's data systems that might affect the accuracy or completeness of network adequacy data used to calculate this indicator?	NA	NA	NA
If encounter or utilization data were used to calculate this indicator, did providers submit data for all encounters?	NA	NA	NA
If LTSS data were used to calculate this indicator, were all relevant LTSS provider services included?	NA	NA	NA
If access and availability studies were conducted to calculate this indicator, does the MCP include all phone calls made in the denominator?	NA	NA	NA
If access and availability studies were conducted to calculate this indicator, does the MCP have processes for addressing potential roadblocks in identification, such as lack of a Medicaid or CHIP ID or medical record number needed to speak with provider offices?	NA	NA	NA
Assessment of MCP Network Adequacy Methods			
Are the methods selected by the MCP to calculate this indicator appropriate for the state?	Y	Y	Y
Are the methods selected by the MCP to calculate this indicator appropriate to the state Medicaid and CHIP population(s)?	Y	Y	Y
Are the methods selected by the MCP adequate to generate the data needed to calculate this indicator?	Y	Y	Y
In calculating this indicator, does the MCP use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist?	Y	Y	Y
If applicable, does the MCP's approach for addressing telehealth match the state's expectations?	NA	NA	NA
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, did the sampling frame contain a complete, recent, and accurate list of the target population?	NA	NA	NA
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, is the sample representative of the population?	NA	NA	NA
If the MCP is sampling a subset of the Medicaid and/or CHIP population to calculate this indicator, are sample sizes large enough to draw statistically significant conclusions?	NA	NA	NA

Question	HB	HSH/ SMHK	UHC
In calculating this indicator, were valid sampling techniques used to protect against bias?	NA	NA	NA
If applicable to this indicator, does the MCP's approach for measuring distance match the state's expectation?	Y	Y	Y
If applicable to this indicator, does the MCP's approach for measuring time match the state's expectation?	Y	Y	Y
If applicable to this indicator, does the MCP's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation?	NA	NA	NA
If applicable to this indicator, does the MCP's approach for determining the maximum wait time for an appointment match the state's expectation?	NA	NA	NA
Are the methods used to calculate this indicator rigorous and objective?	Y	Y	Y
Are the methods used to calculate this indicator unlikely to be subject to manipulation?	Y	Y	Y
Assessment of MCP network adequacy results			
In calculating this indicator, did the MCP produce valid results—that is, did the MCP measure what they intended to measure?	Y	Y	Y
In calculating this indicator, did the MCP produce accurate results—that is, did the MCP's calculated values reflect the true values?	Y	Y	Y
In calculating this indicator, did the MCP produce reliable results—that is, were the MCP's results reproducible and consistent?	Y	Y	Y
In calculating this indicator, did the MCP accurately interpret its results?	Y	Y	Y

Summary of Plan and Program Level NAV Scoring and Ratings

Validation Rating

The validation rating reflects the overall confidence that acceptable methodology was used during all phases of design, data collection, analysis and interpretation of the network adequacy indicators.

Tables 68-69 provide the validation rating legend and an aggregate summary of the validation scores and ratings for all network adequacy indicators by MCP, including an aggregate overview (MO) result at the program level. All MCPs and MO received a validation score of 100% and validation rating of "High Confidence" for all provider network indicators.

Table 68. Validation Rating Legends.

Validation Score	Validation Rating
≥ 90%	High confidence
51% – 89.9%	Moderate confidence
10% – 49.9%	Low confidence
≤ 9.9%	No confidence

Table 69. NAV Score and Ratings.

Plan	Network Adequacy Indicators	# of Scoring Elements	% Score	Validation Rating
HB	All Provider Network Adequacy Indicators	16/16	100%	High confidence
HSH/SMHK	All Provider Network Adequacy Indicators	16/16	100%	High confidence
UHC	All Provider Network Adequacy Indicators	16/16	100%	High confidence
MO	**Overall Provider Network Adequacy Indicators**	**48/48**	**100%**	**High confidence**

**See 2024 Provider Network Adequacy Standards for complete list of provider network adequacy indicators and provider specialties*.

Program Level EQRO Recommendations

Based on program-level findings from the NAV review, the following recommendations are provided to MHD. Overall, the review and validation of network adequacy standards for the MO program level indicate that the MCPs maintain a comprehensive provider network. Overall, the MO program satisfied 231 out of 240 indicators for a result of 96.4% of the network adequacy standards being met.

After completing the Protocol 4 worksheets to assess MCP network adequacy, Comagine Health has high confidence in the data and methods used to calculate provider network access indicator results. No recommendations were identified to improve the reliability or validity of the data, processes or systems used by either the MCPs or MHD to monitor network adequacy, including those related to data systems, methodologies or staffing.

For the provider types and specialties where the MCPs did not meet the time or distance standard, MHD should work with the MCPs to assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs, or other contributing factors.

Progress on Previous Year (2023) Program Level EQRO Recommendation(s)

In February 2023, CMS introduced revised EQR protocols that include a new protocol for mandatory network adequacy validation. States and EQROs were required to implement the new network adequacy validation protocol by February 2024, marking the first year for reporting.

Summary of Plan Level Findings and Recommendations

Tables 70-72 provide an overview of each MCP's findings, including strengths, opportunities for improvement and recommendations. The MHD defined standard is for 100% of enrollees to have access to a provider within the applicable travel time or distance in all categories. Any score of 99.5% and above will be rounded up to 100%. Strengths were given for those indicators at or above 99.5%, while recommendations were given for those indicators below 99.5%.

For more detailed information on the findings, please refer to the individual MCP 2024 EQR NAV reports.

Table 70. HB NAV Findings and Recommendations.

HB NAV Findings and Recommendations
Strengths
Overall, the network adequacy standards review and validation results for HB indicate that the MCP has a comprehensive provider network. HB met 98.8% of the network indicators.
Weaknesses/Opportunities for Improvement
HB did not meet the network access indicators and standards for the following provider types and specialties: • Audiology in the large metro, metro and micro (95.9%) county classifications • Inpatient mental health in the large metro, metro and micro (99.0%) county classifications • Adult chiropractic in the rural (99.4%) county classification
Recommendations
For the provider types and specialties where HB did not meet the time or distance standard, HB should assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs, or other contributing factors.

Table 71. HSH/SMHK NAV Findings and Recommendations.

HSH/SMHK NAV Findings and Recommendations
Strengths
Overall, the network adequacy standards review and validation results for HSH/SMHK indicate that the MCP has a comprehensive provider network. HSH/SMHK met 97.5% of the network indicators.
Weaknesses/Opportunities for Improvement
HSH/SMHK did not meet the network access indicators and standards for the following provider types and specialties: • Adult allergy in the micro (84.8%) and rural (96.8%) county classifications • Pediatric allergy in the micro (84.4%) and rural (96.7%) county classifications • Adult chiropractic in the rural (97.3%) county classification • Pediatric chiropractic in the rural (97.1%) county classification
Recommendations
For the provider types and specialties where HSH/SMHK did not meet the time or distance standard, HSH/SMHK should assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs, or other contributing factors.

Table 72. UHC NAV Findings and Recommendations.

UHC NAV Findings and Recommendations
Strengths
Overall, the network adequacy standards review and validation results for UHC indicate that the MCP has a comprehensive provider network. UHC met 97.9% of the network indicators.
Weaknesses/Opportunities for Improvement
UHC did not meet the network access indicators and standards for the following provider types and specialties: • Audiology in the large metro, metro and micro (97.2%) county classifications • Adult allergy in the metro (96.0%) and micro (95.2%) county classifications

UHC NAV Findings and Recommendations
• Pediatric allergy in the metro (95.5%) and micro (95.3%) county classifications
Recommendations
For the provider types and specialties where UHC did not meet the time or distance standard, UHC should assess whether this is due to a shortage of available providers in the area, a reluctance of providers willing to contract with the MCPs, or other contributing factors.

Progress on Previous Year (2023) Plan Level EQRO Recommendation(s)

In February 2023, CMS introduced revised EQR protocols that include a new protocol for mandatory NAV. States and EQROs were required to implement the new NAV protocol by February 2024, marking the first year for reporting.

Care Management Review (Focus Study)

Objective

According to §438.358 (c)(5), states may direct their EQROs to conduct focus studies for quality improvement, administrative, legislative, or other purposes. Focus studies assess a particular aspect of clinical or nonclinical services at a point in time.

The purpose of this focus study is to identify contributing factors and key drivers, including any challenges within the MCP's CM programs. To ensure an MCP is in compliance with CM requirements in its contract with MHD, Comagine Health completed a comprehensive review of documents and clinical records provided by the MCPs. The information gathered during the review helps assess the quality, access and timeliness of care provided to Medicaid beneficiaries within its CM program.

Overview

The review consisted of two components to assess compliance with CM requirements in its contract with MHD (Amendment 3):

1. **Compliance with Contractual Requirements (referred to in this report as document review)** – an assessment of MCP's compliance with CM contractual requirements, utilizing documentation submitted for selected criteria to be reviewed.

2. **Clinical Records Review (referred to in this report as clinical review)** – an assessment of MCP's compliance with CM contractual requirements, utilizing a review of clinical records submitted for selected criteria to be reviewed.

The reviews include four main areas, including a review of the overall CM program requirements and three specific focus areas.

- Overall Care Management Requirements (OCM)
- Focus Area 1: Multiple Comorbid Conditions (MCC)
- Focus Area 2: Pregnancy/Obstetrics (PO)
- Focus Area 3: Individuals in Foster Care, Receiving Foster Care or an Adoption Subsidy, or Other Out-of-Home Placement, referred to in this report as Foster Care (FC) **[SMHK Only]**

Additionally, these focus areas and overall CM requirements were further categorized into standards (document review) or indicators (clinical review). Note: these standards/indicators fall under the domains of quality, access and timeliness of health care and services.

Document Review

Tables 73–76 below lists the document review standards by focus area.

Table 73. Document Review Overall Care Management Standards.

Std.	OCM Contract Section (*Amendment 3*)
OCM1	Principles of CM – 2.12.1 (a)(1-8)(10)
OCM2	Principles of CM – 2.12.1 (a)(9)
OCM3	Member CM Program Requirements – 2.12.1 (b)

Std.	OCM Contract Section (*Amendment 3*)
OCM4	General Health Plan Policy Requirements – CM Record Documentation – 2.12.1 (c)
OCM5	General Health Plan Policy Requirements – 2.12.1 (d)(1-2); Comprehensive Benefit Package Requirements 2.8.12
OCM6	General Eligibility and Assessment for CM – 2.12.1 (e)
OCM7	CM Closure – 2.12.1 (g)

Table 74. Document Review Focus Area 1: MCC Standards.

Std.	MCC Contract Section (*Amendment 3*)
MCC1	General Eligibility and Assessment for CM – 2.12.1 (e)(2, 4)
MCC2	Coordination with Private Duty Nursing Services – 2.12.1 (f)

Table 75. Document Review Focus Area 2: PO Standards.

Std.	PO Contract Section (*Amendment 3*)
PO1	CM Closure – 2.12.1 (g)
PO2	Transition of CM – 2.12.3 (g)
PO3	Transition of CM – 2.12.3 (h)
PO4	Transition of CM – 2.12.3 (k)
PO5	CM Closure – 2.12.1 (g)
PO6	Transition of CM – 2.12.3 (g)

Table 76. Document Review Focus Area 3: FC (SMHK only).

Std.	FC Contract Section (*Amendment 3*)
FC1	Coordination with Services not Included in the Specialty Plan Benefit Package Requirements – 3.8.1
FC2	Member CM, Disease Management, Hospital Care Transition, and Transition of Care Requirement – 3.9.1
FC3	General Requirements of Member CM – 3.9.2 (c)(d)
FC4	Principles of CM – 3.9.3 (a-d)(i)
FC5	CM Program Plan – 3.9.4
FC6	CM Training – 3.9.6
FC7	CM Tiers – 3.9.7
FC8	CM Assignment – 3.9.8
FC9	CM Coordination and Accountability –3.9.9
FC10	CM Activities – 3.9.10
FC11	CM Information Systems and Analytics – 3.9.12
FC12	CM Policy Requirements – 3.9.15 (a)
FC13	Member Transition of Care – 3.9.16

Clinical Review

The clinical review focus areas include OCM CM requirements within each of the focus areas. Random samples of clinical records were generated for each focus area and the members were evaluated against contract requirements in effect during the review period of January 1–December 31, 2023.

Tables 77-79 below list the clinical review indicators for each focus area.

Table 77. Clinical Review Focus Area 1: MCC Indicators.

Ind.	MCC Description
MCC1	Assessment (or other documentation in the record) was comprehensive
MCC2	Assessments occurred timely
MCC3	Disease management (DM) was offered timely
MCC4	The “opt out” methodology for DM was utilized
MCC5	Additional outreach efforts for unsuccessful contacts for members with multiple comorbid conditions
MCC6	Care plan was comprehensive
MCC7	Required care planning processes were documented
MCC8	Care plans were updated timely
MCC9	Evidence of coordination and follow-up were documented in the record
MCC10	Appropriate referrals were documented in the record
MCC11	The CM closure requirements were satisfied

Table 78. Clinical Review Focus Area 2: PO Indicators.

Ind.	PO Description
PO1	Assessment (or other documentation in the record) was comprehensive
PO2	Assessments occurred timely
PO3	CM was offered timely to pregnant members
PO4	Additional outreach efforts for unsuccessful contacts for pregnant members
PO5	Care plan was comprehensive
PO6	Required care planning processes were documented
PO7	Care plans were updated timely
PO8	Evidence of coordination and follow-up were documented in the record
PO9	Timely follow-up for postpartum medical appointments
PO10	Appropriate assistance is provided to pregnant members
PO11	Appropriate referrals were documented in the record
PO12	The CM closure requirements were satisfied

Table 79. Clinical Review Focus Area 3: FC Indicators [SMHK only].

Ind.	FC Description
FC1	Assessment (or other documentation in the record) was comprehensive
FC2	Assessments occurred timely
FC3	Specialty plan member’s tier assignment is re-evaluated as required
FC4	Care plan was comprehensive

Ind.	FC Description
FC5	Required care planning processes were documented
FC6	Care plans were updated timely
FC7	Evidence of coordination and follow-up were documented in the record
FC8	Appropriate referrals were documented in the record
FC9	The CM closure requirements were satisfied

Methodology

Document Review & Clinical Review

The document review and clinical record review were conducted using review tools and reviewer guidelines developed by Comagine Health and MetaStar and approved by MHD.

Documentation for each focus area were evaluated against contract requirements in effect during the review period of January 1–December 31, 2023.

For a full description of the methodology, including technical methods of data collection, description of data obtained and how Comagine Health aggregated and analyzed the data, please see Appendix E: CM Review Methodology.

Summary of Care Management Review Results

Document Review

The document review assesses activities for the previous calendar year and evaluates MCP's compliance with the CM standards set forth in its contract with MHD.

Table 80 presents the scoring key, while Table 81 summarizes all MCPs and provides an aggregate overview (MO) of their results at the program level. For more detailed information on the results, please refer to the individual MCP *2024 CM reports.*

Table 80. Document Review Scoring Legend.

Star Rating Scale	
Score	**Compliance Rating**
90% - 100%	Fully Met
80% - 89.9%	Substantially Met
70% - 79.9%	Partially Met
60% - 69.9%	Minimally Met
≤ 59.9%	Not Met
NA	Not Applicable

Table 81. Individual MCP Document Review and Program Level Results.

Std.	Contract Citation	HB	HSH	SMHK	UHC	MO*
OCM1	Principles of CM – 2.12.1 (a)(1-8)(10)	100%	100%	NA	100%	100%
OCM2	Principles of CM – 2.12.1 (a)(9)	100%	100%	NA	100%	100%
OCM3	Member CM Program Requirements – 2.12.1 (b)	100%	100%	NA	100%	100%
OCM4	CM Record Documentation – 2.12.1 (c)	100%	100%	NA	100%	100%
OCM5	General Health Plan Policy Requirements – 2.12.1 (d)(1-2); Comprehensive Benefit Package Requirements 2.8.12)	50%	100%	NA	50%	66.7%
OCM6	General Eligibility and Assessment for CM – 2.12.1 (e)(1)	0%	100%	NA	0%	33.3%
OCM7	CM Closure – 2.12.1 (g)(1-3)	100%	100%	NA	100%	100%
MCC1	General Eligibility and Assessment for CM – 2.12.1 (e)(2, 4)	60%	80%	NA	80%	73.3%
MCC2	Coordination with Private Duty Nursing (PDN) Services – 2.12.1 (f)	100%	100%	NA	91.7%	97.2%
PO1	Participation in Show Me ECHO projects – 2.1.7 (g)(2)	100%	100%	NA	100%	100%
PO2	General Eligibility and Assessment for CM – 2.12.1 (e)(6)	94.7%	100%	NA	42.1%	78.9%
PO3	CM Closure – 2.12.1 (g)	100%	100%	NA	100%	100%
PO4	Transition of CM – 2.12.3 (g)	100%	100%	NA	100%	100%
PO5	Transition of CM – 2.12.3 (h)	100%	100%	NA	100%	100%
PO6	Transition of CM – 2.12.3 (k)	100%	100%	NA	0%	66.7%
FC1	Coordination with Services not Included in the Specialty Plan Benefit Package Requirements – 3.8.1	NA	NA	100%	NA	100%
FC2	Member CM (CM), Disease Management (DM), Hospital Care Transition (HCT), and Transition of Care (TOC) Requirement – 3.9.1	NA	NA	100%	NA	100%
FC3	General Requirements of Member CM – 3.9.2 (c)(d)	NA	NA	100%	NA	100%
FC4	Principles of CM – 3.9.3 (a-d)(i)	NA	NA	100%	NA	100%
FC5	CM Program Plan – 3.9.4	NA	NA	100%	NA	100%
FC6	CM Training – 3.9.6	NA	NA	100%	NA	100%
FC7	CM Tiers – 3.9.7	NA	NA	100%	NA	100%
FC8	CM Assignment – 3.9.8	NA	NA	100%	NA	100%
FC9	CM Coordination and Accountability – 3.9.9	NA	NA	100%	NA	100%
FC10	CM Activities – 3.9.10	NA	NA	100%	NA	100%
FC11	CM Information Systems and Analytics – 3.9.12	NA	NA	100%	NA	100%
FC12	CM Policy Requirements – 3.9.15 (a)	NA	NA	100%	NA	100%
FC13	Member Transition of Care – 3.9.16	NA	NA	100%	NA	100%

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores. SMHK is the sole provider of foster care services for the Medicaid program.*

Clinical Review

The clinical review assesses activities for the previous calendar year and evaluates MCP's compliance with the CM standards set forth in its contract with MHD.

The scoring legend is shown below, while Table 82 provides a summary of all MCP results, including an aggregate overview (MO) at the program level. For more detailed information on the results, please refer to the individual MCP *2024 CM reports.*

Scoring Legend

- **Strength** = indicator rate at or above 86%
- **Compliant** = indicator rate between 85.9% and 80%
- **Opportunity for improvement** = indicator rate at or below 79.9%

Table 82. Individual MCP Clinical Review and Program Level Results.

Ind.	Contract Citation	HB	HSH	SMHK	UHC	MO*
MCC1	Assessment (or other documentation in the record) was comprehensive	71.4%	90.6%	NA	47.1%	69.3%
MCC2	Assessments occurred in a timely way	100%	93.3%	NA	91.2%	94.9%
MCC3	Disease management (DM) was offered in a timely way	100%	97.8%	NA	86.7%	94.8%
MCC4	The "opt out" methodology for DM was utilized	50%	18.2%	NA	18.2%	23.1%
MCC5	Additional outreach efforts for unsuccessful contacts for members with multiple comorbid conditions	0%	0%	NA	0%	0%
MCC6	Care plan was comprehensive	100%	96.9%	NA	97.1%	98%
MCC7	Required care planning processes were documented	94.3%	78.1%	NA	44.1%	72.3%
MCC8	Care plans were updated in a timely way	100%	90.3%	NA	93.1%	94.6%
MCC9	Evidence of coordination and follow-up were documented in the record	100%	100%	NA	100%	100%
MCC10	Appropriate referrals were documented in the record	100%	100%	NA	100%	100%
MCC11	The CM closure requirements were satisfied	87.9%	91.7%	NA	69.2%	83.1%
PO1	Assessment (or other documentation in the record) was comprehensive	85.7%	88.6%	NA	100%	91.4%
PO2	Assessments occurred timely	100%	60.7%	NA	81%	82.1%
PO3	CM was offered timely to pregnant members	100%	84.2%	NA	93.3%	92.9%
PO4	Additional outreach efforts for unsuccessful contacts for pregnant members	75%	60%	NA	88.9%	71.4%
PO5	Care plan was comprehensive	100%	100%	NA	100%	100%
PO6	Required care planning processes were documented	94.3%	97.1%	NA	94.3%	95.2%
PO7	Care plans were updated timely	96.8%	100%	NA	100%	99%
PO8	Evidence of coordination and follow-up were documented in the record	100%	100%	NA	100%	100%

Ind.	Contract Citation	HB	HSH	SMHK	UHC	MO*
PO9	Timely follow-up for postpartum medical appointments	NA	NA	NA	100%	100%
PO10	Appropriate assistance is provided to pregnant members	97.1%	91.4%	NA	100%	96.2%
PO11	Appropriate referrals were documented in the record	100%	100%	NA	100%	100%
PO12	The CM closure requirements were satisfied	85.2%	95.7%	NA	96.7%	92.5%
FC1	Assessment (or other documentation in the record) was comprehensive	NA	NA	51.1%	NA	51.1%
FC2	Assessments occurred timely	NA	NA	62.2%	NA	62.2%
FC3	Specialty plan member's tier assignment is re-evaluated as required	NA	NA	86.7%	NA	86.7%
FC4	Care plan was comprehensive	NA	NA	84.4%	NA	84.4%
FC5	Required care planning processes were documented	NA	NA	15.6%	NA	15.6%
FC6	Care plans were updated timely	NA	NA	31.8%	NA	31.8%
FC7	Evidence of coordination and follow-up were documented in the record	NA	NA	62.2%	NA	62.2%
FC8	Appropriate referrals were documented in the record	NA	NA	100%	NA	100%
FC9	The CM closure requirements were satisfied	NA	NA	96.7%	NA	96.7%

**Aggregate MCP point values were totaled and the sum was divided by the aggregate number of applicable elements in the standard to derive percentage scores.*

Program Level Care Management Review EQRO Recommendation(s)

Based on the program level findings from the CM review, the following recommendations are provided to MHD.

Document Review

Based on the program level findings from the document review of the CM review, weaknesses or opportunities for improvement were identified for any standard that is below 80% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following standards and will benefit from technical assistance by MHD to ensure the plans meet these requirements.[16] MCP-specific recommendations are provided in the individual MCP 2024 CM reports.

- General Health Plan Policy Requirements (66.7%) **(OCM5)**
  - Two of the three MCPs scored 50% on the standard.
- General Eligibility and Assessment for CM (33.3%) **(OCM6)**
  - Two of the three MCPs scored 0% on this standard.
- General Eligibility and Assessment for CM (73.3%) **(MCC1)**

[16] SMHK was not reviewed on these standards and received a 100% score on the standards the MCP was subject to during this review, thus no recommendations were given.

  - All three MCPs scored at 80% or below on this standard.
- General Eligibility and Assessment for CM (78.9%) **(PO2)**
  - Two out of the three MCPs did not score 100% on this standard, including one of the two MCPs scoring 42.1%.
- Transition of CM (66.7%) **(PO6)**
  - One of the three MCP scored 0% on this standard.

Clinical Review

Based on the program level findings from the clinical review section of the CM review, weaknesses or opportunities for improvement were identified for any indicator that is below 80% and are presented as a recommendation to MHD.

The MCPs did not meet all elements for the following indicators and will benefit from technical assistance by MHD to ensure the plans meet these requirements. MCP-specific recommendations are provided in the individual MCP 2024 CM reports.

- Ensure records document the member's developmental history as well as cultural and linguistic needs **(MCC1)**.
- Ensure the member's choice to "opt out" is documented in the record for members not receiving DM services **(MCC4)**.
- Consider conducting face-to-face outreach for members who cannot be reached via telephone or mail **(MCC5)**.
- Ensure care plans are shared with the member's health care provider **(MCC7)**.
- Implement processes to complete additional outreach attempts for members who have lost contact with the CM prior to CM closure **(MCC11)**.
- Focus efforts to complete assessments timely **(PO2)**.
- Implement processes to make additional outreach attempts when telephonic attempts are unsuccessful **(PO4)**.
- Ensure records include documentation of legal information and issues **(FC1)**.
- Focus efforts to complete assessments timely **(FC2)**.
- Ensure care plans are comprehensive **(FC4)**.
- Ensure processes for sharing care plans with the member's health care provider are documented **(FC5)**.
- Ensure processes for sharing care plans with the Children's Division are documented **(FC6)**.
- Focus effort on CM accountability for coordination by ensuring gaps in care are coordinated **(FC7)**.

Progress on Previous Year (2023) Program Level Care Management Review EQRO Recommendation(s)

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Summary of Plan Level Care Management Review Findings

Document Review

Strengths are defined as standards that scored at or above 90%. Weaknesses, or opportunities for improvement, are included for any standard that is below 90%, and any scoring element that was not met. Additional opportunities for improvement may be included for elements that are minimally compliant. Recommendations are included for all weaknesses/opportunities for improvement.

MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance. An update of the current year's EQRO recommendations will be reflected in the 2025 Annual Technical Report.

The following provides the major themes of the individual document review findings for the MCPs. For more detailed information on the findings, please refer to the individual MCP CY2024 EQR CM reports.

Healthy Blue

Tables 83-84 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for HB.

Table 83. HB: Strengths.

Strengths
Overall CM Requirements (OCM)
• HB complied with contractual requirements for Transitions of Care **(OCM2)** and CM Record Documentation **(OCM4)**. • The interviews with HB staff identified a number of different resources available to support CM staff in their roles, including supervisor support, staff meetings, regular interdisciplinary rounding meetings for case consultations and problem solving, and a number of different trainings to build skill sets **(OCM1)**. • HB implemented procedures to deliver care to and coordinate services for all MCP members **(OCM3)**. • Guideline criteria for case closure are specific, comprehensive and based on achievement of goals stated in the care plan. Providing referrals and resources to support members needs post CM is adequately addressed by HB. Comprehensive guidelines for contacting member and what requirements for closure of CM to be considered criteria of "unable to contact." **(OCM7)**.

Strengths
Multiple Comorbid Conditions (MCC)
• HB provides health risk screenings as well as initial and follow-up assessments which promotes identification of early disease development. The health plan uses the initial assessment to identify any unique needs of the member to start the formulation of the member's care plan if CM is initiated **(MCC1)**. • The primary care health homes provide CM for all conditions stated. Policy includes examples of care coordination such as including joint rounds, joint home or facility visits involving both Behavioral Health and Health CM Care Managers, claims data review and coordination of referral to needed community support services **(MCC2)**.
Pregnancy/Obstetrics (PO)
• HB complied with contractual requirements for CM Closure **(PO3)**, Transition of CM **(PO4)** and Transition of CM **(PO5).** • HB participated in all required Show Me ECHO projects and records of member attendance were provided **(PO1)**. • HB makes reasonable efforts to obtain an initial health screening assessment if there is the belief that the member is pregnant. "Urgent Pregnancy Risk" members are considered the priority for outreach and engagement. "All members, regardless of risk acuity, receive educational information and are continually monitored throughout the Digital Perinatal Program." **(PO2)** • HB ensures that if a provider is terminated (voluntarily or involuntarily), the member may receive up to 90 calendar days or through the current period of active treatment, whichever is less. HB actively assists members who are undergoing an active course of treatment or services for a chronic or acute medical condition in the transition to another provider and collaborates with the provider to develop a reasonable transition plan that occurs without a disruption of care of lapse in service **(PO6)**.

Table 84. HB: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, HB should:
• Develop and implement a method to monitor screening timeframes and evaluate the data for compliance with requirements **(OCM 5)**. • Develop and implement a method to aggregate the results from the auditing processes, specifically for the assessment timeframes and evaluate the data for compliance with requirements **(OCM6)**. • Develop and implement a method to aggregate the results from the auditing processes, specifically for the assessment timeframes and evaluate the data for compliance with requirements **(MCC1)**. • Ensure website links used to disseminate clinical practice guideline to providers are functional **(MCC1)**. • Recommend the plan correct the error in the Health Risk Assessment policy to state that the enrollee shall be screened "within fifteen (15) business days of enrollment" **(PO2)**.

Home State Health/Show Me Healthy Kids

Tables 85-86 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for HSH/SMHK.

Table 85. HSH/SMHK: Strengths.

Strengths
HSH
Overall CM Requirements (OCM)
• HSH complied with contractual requirements for Principles of CM – Transitions of Care **(OCM2)**, CM Record Documentation **(OCM4)** and General Health Plan Policy Requirements **(OCM5)**. • HSH implemented procedures to deliver care to and coordinate services for all MCP members **(OCM1)**. • HSH demonstrated comprehensive CM programs, which emphasized the importance of member experiences and outcomes. Detailed information on roles and responsibilities and staff qualifications were included. The interviews highlighted a number of resources and supports available to care managers, including a SharePoint site to easily look up policies and procedures and other job-related topics, supervisor support and a comprehensive training plan to aid in onboarding new staff, as well as ample opportunity for ongoing education **(OCM3)**. • The CM care plan also included prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers **(OCM7)**. • HSH "Start Smart for Your Baby Program Overview" specifies that one of the essential components of the program is to identify pregnant members and their risk factors as early in pregnancy as possible **(MCC1)**. • HSH includes very extensive methods in their policy for identifying members with a diagnosis eligible for enrollment in a disease management program **(MCC1)**. • HSH includes coordination of the transition of care in the CM Workflow document for Health Home Discharges **(MCC2)**.
Pregnancy/Obstetrics (PO)
• HSH complied with contractual requirements for Participation in Show Me ECHO Projects **(PO1)**, CM Closure **(PO3)**, and Transition of CM **(PO4)(PO5)**. • HSH clearly stated in two different policies that CM will be offered within 15 business days of the notice of pregnancy **(PO2)**. • The risk appraisal tool used is a gradient boosting model which produces a prediction model in the form of decision trees to better stratify pregnant members. Higher risk members are prioritized for outreach by health plan staff **(PO2)**. • HSH references referrals to substance-related treatment services in two different documents thereby ensuring that substance-related treatment is provided to all members **(PO2)**. • The tracking mechanism used by the plan for monitoring appointment attendance can potentially be used for identifying trends through a root cause analysis process to determine if intervention could improve outcomes **(PO2)**.

Strengths
• Continuation of care with a terminated provider is allowed under certain circumstances if the provider is not terminated due to a quality issue. When a member changes physicians due to termination from network or by member choice, the plan will assist with transfer of the medical records to the new provider as needed **(PO6)**.
SMHK
Individuals in Foster Care, Receiving Foster Care or an Adoption Subsidy, or Other Out-of-Home Placement, referred to in this report as Foster Care (FC)

• SMHK complied with contractual requirements for
  ○ SMHK complied with contractual requirements for Coordination with Services Not Included in the Specialty Plan Benefit Package Requirements **(FC1)**
  ○ CM, DM, HC and TOC Requirement **(FC2)**
  ○ General Requirements of Member CM **(FC3)**
  ○ CM Training **(FC6)**
  ○ CM Tiers **(FC7)**
  ○ CM Coordination and Accountability **(FC9)**
• SMHK implemented mechanisms to comprehensively assess each Medicaid enrollee identified by the state, and identified to SMHK by the state, as having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring **(F4)**.
• SMHK demonstrated comprehensive CM programs, which emphasized the importance of member experiences and outcomes. Detailed information on roles and responsibilities and staff qualifications were included. The interviews highlighted a number of resources and supports available to care managers, including a SharePoint site to easily look up policies and procedures and other job-related topics, supervisor support and a comprehensive training plan to aid in onboarding new staff, as well as ample opportunity for ongoing education **(FC5)**.
• SMHK provides information to member, PCP and entities involved in performing CM activities and care planning, regarding members risk assignment and consider requests to reassign risk level **(FC8)**.
• Guidelines for outreach for CM are specified for members at Tiers 1-4 levels. Outreach frequency varies depending on which tier the member is assigned to **(FC8)**.
• SMHK policy includes condition-specific assessment, such as the Diabetes and Asthma assessment, and are derived from evidence-based clinical guidelines. During the in-depth case management assessment, the Care Manager evaluates the full scope of the member's situation **(FC10)**.
• SMHK provided many examples of referrals for community outreach events focusing on wellness and prevention. Plan also provides a resource for a cell phone program **(FC10)**.
• SMHK has "Prior Authorization Nurses" who manage the clinical review and determinations or preservice authorization requests **(FC10)**.
• SMHK Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital case managers and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. Document provided also notes that this is especially important for

Strengths
complex or special needs cases as members often see several providers to manage their condition. Providers are educated on the importance of cross-communication in the provider handbook and ad-hoc training sessions. Compliance is monitored during random medical record reviews **(FC10)**. • SMHK has automated CM workflows which includes clinical decision support criteria for utilization management. SMHK has integrated InterQual medical necessity criteria into their CM platform to assist in making appropriate medical decisions based on nationally accepted, evidence-based standards of care. The CM platform centers on the member's care as a whole versus isolated clinical cases, permitting their staff to more easily collaborate and focus on the member's care in a holistic manner. SMHK integrates care plans created by the CM staff in the CM platform with the Provider Portals so that providers have access to one care plan for monitoring goals and progress **(FC11)**. • SMHK demonstrated monitoring of CM practices through the use of a dashboard to track timeliness of assessments and other requirements, as well as a comprehensive audit tool to monitor the requirements of CM practices. The audit tool results are shared at the individual CM level, as well as aggregated to identify program level findings, trends and gaps **(FC12)**. • All new members to SMHK have a 180-day continuity of care period for any care that began prior to joining SMHK. During this 180-day period, 100% Medicaid reimbursement will be provided to Medicaid-enrolled providers who are willing to bill HSH without any additional authorization **(FC13)**.

Table 86. HSH/SMHK: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review:
HSH should:
• Add to its policies and procedure that DM will be offered to members as early as possible in the development of all disease states in addition to pregnancy **(MCC1)**.
SMHK
SMHK did not receive recommendations for improvement for the document review portion of the CM Review.

UnitedHealthcare

Tables 87-88 describe the strengths and recommendations, with the applicable standard, based on weaknesses/opportunities for improvement for UHC.

Table 87. UHC: Strengths.

Strengths
Overall CM Requirements (OCM)
• UHC complied with contractual requirements for Principles of CM – Transitions of Care **(OCM2)**, CM Record Documentation **(OCM4)**. • UHC implemented procedures to deliver care to and coordinate services for all MCP members **(OCM1)**. • The interviews with MCP staff indicated a variety of trainings and resources available to care managers to support them in their roles, including weekly interdisciplinary "rounding" meetings for case consultations and problem solving on challenging situations **(OCM3)**. • The UHC care manager and member will modify and re-evaluate goals as well as the plan of care based on the member's accomplishments and progress **(OCM7)**.
Multiple Comorbid Conditions (MCC)
• UHC had a comprehensive list of strategies for identifying members appropriate for DM **(MCC1)**. • Policy for Primary Care Health Homes has broad definition of what conditions are eligible for CM **(MCC2)**.
Pregnancy/Obstetrics (PO)
• UHC complied with contractual requirements for Participation in Show Me ECHO Projects **(PO1)**, CM Closure **(PO3)** and Transition of CM **(PO4)(PO5)**. • UHC policy specifically addresses who completes the assessment and the assessment types **(PO2)**. • Policy Includes statement that risk stratification will be validated through contact with member and/or provider **(PO2)**. • Document includes statement of "ensure that first PNV is completed." Policy includes statement of provides appointment "immediately if an emergency exists." **(PO2)** • Appointment compliance is included in the care plan and updated throughout the case **(PO2)**. • Plan generates a letter that goes to a child's family when a member is overdue for an annual visit or Early Periodic Screening, Diagnosis and Treatment **(PO2)**. • Plan notifies current health care providers when CM services are discontinued and why the services are discontinued **(PO2)**.

Table 88. UHC: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement – Based on the results of the review, UHC should:
• Develop and implement a method to aggregate the results from the auditing process, specifically for the screening timeframes and evaluate the data for compliance with requirements **(OCM5)**. • Develop and implement a method to aggregate the results from the auditing processes, specifically for the assessment timeframes and evaluate the data for compliance with requirements **(OCM6)**. • Develop and implement a method to aggregate the results from the auditing processes, specifically for the assessment timeframes and evaluate the data for compliance with requirements **(MCC1)**. • Add specific language to the Dental Job Aid policy requiring that a referral for an annual dental visit must be included within six weeks of enrollment **(PO2)**.

Clinical Record Review

A strength is identified as an indicator rate at or above 86%, while opportunity for improvement is an indicator rate at 79.9% or lower. Recommendations are included for all opportunities for improvement.

MCPs were reviewed in the first half of the calendar year. Because MCPs may have implemented CAPs since that time to address specific issues, these recommendations may not be indicative of current performance. An update of the current year's EQRO recommendations will be reflected in the 2025 Annual Technical Report. For more detailed information on the findings, please refer to the individual MCP 2024 EQR CM Report.

The following provides the major themes of the individual clinical review findings for the MCPs. Note: The clinical review focus areas included the OCM CM requirements within each of the focus areas.

Healthy Blue

Tables 89-90 describe the strengths and recommendations, with the applicable indicator, based on weaknesses/opportunities for improvement for HB.

Table 89. HB: Strengths.

Strengths
Multiple Comorbid Conditions (MCC)
• Assessments occurred in a timely way **(MCC2)**. • Disease management (DM) was offered in a timely way **(MCC3)**. • Care plan was comprehensive **(MCC6)**. • Required care planning processes were documented **(MCC7)**. • Care plans were updated timely **(MCC8)**. • Evidence of coordination and follow-up were documented in the record **(MCC9)**. • Appropriate referrals were documented in the record **(MCC10)**. • The CM closure requirements were satisfied **(MCC11)**.
Pregnancy/Obstetrics (PO)
• Assessments occurred timely **(PO2)**. • CM was offered timely to pregnant members **(PO3)**. • Care plan was comprehensive **(PO5)**. • Required care planning processes were evidenced **(PO6)**. • Care plans were updated timely **(PO7)**. • Evidence of coordination and follow-up were documented in the record **(PO8)**. • Appropriate assistance was provided to pregnant members **(PO10)**. • Appropriate referrals were documented in the record **(PO11)**.

Table 90. HB: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement
• Ensure records document each distinct condition for which the member is being managed **(MCC1)**. • Ensure the member's choice to "opt out" is documented in the record for members not receiving DM services **(MCC4)**. • Consider conducting face-to-face outreach for members who cannot be reached via telephone or mail **(MCC5)**. • Implement processes to make additional outreach attempts when telephonic attempts are unsuccessful **(PO4)**.

Home State Health/Show Me Healthy Kids

Tables 91-92 describe the strengths and recommendations, with the applicable indicator, based on weaknesses/opportunities for improvement for HSH/SMHK.

Table 91. HSH/SMHK: Strengths.

Strengths
Multiple Comorbid Conditions (MCC)
• Assessment (or other documentation in the record) was comprehensive **(MCC1)**. • Assessments occurred in a timely way **(MCC2)**. • Disease management (DM) was offered in a timely way **(MCC3)**. • Care plans were comprehensive **(MCC6)**. • Care plans were updated timely **(MCC8)**. • Evidence of coordination and follow-up were documented in the record **(MCC9)**. • Appropriate referrals were documented in the record **(MCC10)**. • The CM closure requirements were satisfied **(MCC11)**.
Pregnancy/Obstetrics (PO)
• Assessment (or other documentation in the record) was comprehensive **(PO1)**. • Care plans were comprehensive **(PO5)**. • Required care planning processes were evidenced **(PO6)**. • Care plans were updated timely **(PO7)**. • Evidence of coordination and follow-up was documented in the record **(PO8)**. • Appropriate assistance was provided to pregnant members **(PO10)**. • Appropriate Referrals were documented in the record **(PO11)**. • The CM closure requirements were satisfied **(PO12)**.

Strengths
Foster Care (SMHK Only)
• Specialty plan member's tier assignment was re-evaluated as required **(FC3)**. • Appropriate referrals were documented in the record **(FC8)**. • The CM closure requirements were satisfied **(FC9)**.

Table 92. HSH/SMHK: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement
• Ensure the member's choice to "opt out" is documented in the record for members not receiving DM services **(MCC4)**. • Consider conducting face-to-face outreach for members who cannot be reached via telephone or mail **(MCC5)**. • Ensure care plans are shared with the member's health care provider **(MCC7)**. • Focus efforts to complete assessments timely **(PO2)**. • Implement processes to make additional outreach attempts when telephonic attempts are unsuccessful **(PO4)**. • Ensure records include documentation of legal information and issues **(FC1)**. • Focus efforts to complete assessments timely **(FC2)**. • Ensure processes for sharing care plans with the member's health care provider are documented **(FC5)**. • Ensure processes for sharing care plans with the Children's Division are documented **(FC6)**. • Focus effort on CM accountability for coordination by ensuring gaps in care are coordinated **(FC7)**.

UnitedHealthcare

Tables 93-94 describe the strengths and recommendations, with the applicable indicator, based on weaknesses/opportunities for improvement for UHC.

Table 93. UHC: Strengths.

Strengths
Multiple Comorbid Conditions (MCC)
• Assessments occurred in a timely way **(MCC2)**. • Disease management (DM) was offered in a timely way **(MCC3)**. • Care plans were comprehensive **(MCC6)**. • Care plans were updated timely **(MCC8)**. • Evidence of coordination and follow-up were documented in the record **(MCC9)**. • Appropriate referrals were documented in the record **(MCC10)**.

Strengths
Pregnancy/Obstetrics (PO)
• Assessment (or other documentation in the record) was comprehensive **(PO1)**. • CM was offered timely to pregnant members **(PO3)**. • Additional outreach efforts for unsuccessful contacts for pregnant members were evidenced **(PO4)**. • Care plans were comprehensive **(PO5)**. • Required care planning processes were evidenced **(PO6)**. • Care plans were updated timely **(PO7)**. • Evidence of coordination and follow-up were documented in the record **(PO8)**. • Timely follow-up for postpartum medical appointments was evidenced **(PO9)**. • Appropriate assistance was provided to pregnant members **(PO10)**. • Appropriate Referrals were documented in the record **(PO11)**. • The CM closure requirements were satisfied **(PO12)**.

Table 94. UHC: Recommendations Based on Weaknesses/Opportunities for Improvement.

Recommendations Based on Weaknesses/Opportunities for Improvement
• Ensure records document the member's developmental history as well as cultural and linguistic needs **(MCC1).** • Ensure the member's choice to "opt out" is documented in the record for members not receiving DM services **(MCC4)**. • Consider conducting face-to-face outreach for members who cannot be reached via telephone or mail **(MCC5)**. • Ensure care plans are shared with the member's health care provider **(MCC7)**. • Implement processes to complete additional outreach attempts for members who have lost contact with the CM prior to CM closure **(MCC11)**.

Progress on Previous Year (2023) Plan Level EQRO Recommendation(s)

MHD contracted with Comagine Health as the EQRO, effective January 1, 2024. At the time of this review, the final *2023 EQR Annual Technical Report* (review period CY2022) was not available. As a result, progress cannot be identified.

Appendix A: PIP Validation Methodology

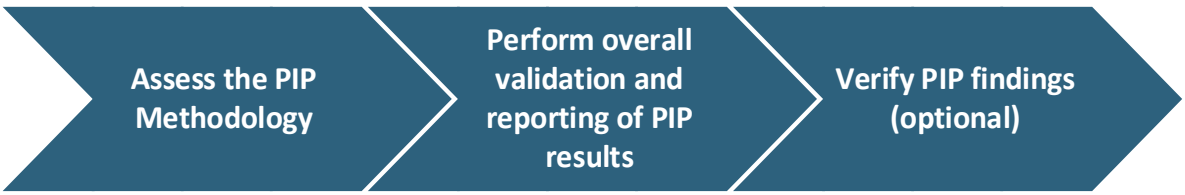
The intent of the PIP validation process is to ensure that a PIP contains sound methodology in its design, implementation, analysis and reporting of its results. It is crucial that the PIP has a comprehensive and logical thread that ties each aspect (e.g., aim statement, sampling methodology and data collection) together.

As required under *CMS Protocol 1. Validation of Performance Improvement Projects (PIPs)*, Comagine Health determined whether PIP validation criteria were Met, Partially Met or Not Met. In addition, Comagine Health utilizes validation ratings in reporting the results of the MCPs' PIPs.

Technical Methods of Data Collection

The PIP validation, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted June through October 2024, using the review period of CY2023. The review followed the guidelines from *Worksheets for Protocol 1. PIP Validation Tools and Reporting Framework*, a set of worksheets used to guide and record answers for the validation of PIPs and reporting of summary PIP information, developed by CMS to determine whether a PIP was designed, conducted and reported in a methodologically sound manner.

CMS Protocol 1 specifies procedures in assessing the validity and reliability of a PIP and how to conduct the following three activities:



Activity 1 (Standards): Assess the PIP Methodology

1. Review the selected PIP topic to assess the appropriateness of the selected topic
2. Review the PIP aim statement to assess the appropriateness and adequacy of the aim statement
3. Review the identified PIP population to assess the whether the population was appropriately identified
4. Review the appropriateness of the sampling method
5. Review the appropriateness of the selected PIP variables and performance measures
6. Review the appropriateness of the study variables and performance measures used to track improvement in the data collection procedures
7. Review the data analysis and interpretation of PIP results to assess the quality and completeness of the analysis
8. Assess whether the improvement strategies selected were appropriate for achieving improvement
9. Assess the likelihood that significant and sustained improvement occurred was the result of the PIP

Activity 2: Perform Overall Validation & Reporting of PIP Results

Following the completion of Activity 1, the EQRO will provide two validation ratings of the PIP results.

- **Validation Rating 1:** The EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases.
- **PIP Validation Rating 2:** The EQRO's overall confidence that the PIP produced evidence of significant improvement.

The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement.

Comagine Health utilizes one of the following validation ratings in reporting the results of the MCPs' PIPs:

- High confidence in reported results
- Moderate confidence in reported results
- Low confidence in reported results
- No confidence in reported results

Activity 3: Verify PIP Findings (Optional)

A state may request that the EQRO verify the data produced by the MCP to determine if the baseline and repeated measurements are accurate. The MCPs' data was based on the following:

- HEDIS measures, which have been validated via the MY2023 HEDIS compliance audit process conducted according to the standards and methods described in the NCQA HEDIS® Compliance Audit™ Standards, Policies and Procedures.
- CAHPS survey results. The CAHPS program is a public-private initiative that develops standardized surveys to measure patients' experiences with healthcare. The surveys are designed to be reliable and to allow for comparisons across healthcare settings. These surveys cover topics that are important to consumers, such as the communication skills of providers and how easy it is to access health care services.

Therefore, Comagine Health did not verify the data produced by the MCPs.

Description of Data Obtained

Comagine Health validates each PIP using data gathered and submitted by the MCP using the Research Electronic Data Capture (REDCap) system based on the *Worksheets for Protocol 1. PIP Validation Tools and Reporting Framework*. REDCap is a secure web-based application designed for data collection and management in research and clinical studies.

Data Aggregation and Analysis

As the MCPs submit their PIP data directly within the protocol worksheets, all elements necessary for the validation of the PIP is submitted and readily available for Comagine Health to validate.

The Comagine Health scoring method for evaluating PIPs is outlined below.

Scoring

Validation Rating

Each standard has a specified number of scoring elements, which correlate to the PIP validation worksheets. Element score results are presented as either "Yes," "No" or "Not Applicable (NA)" based on the reviewer's evaluation of the MCP's responses and documents submitted. Elements scored NA are not reviewed and are not included in the final scoring. Standard scores are presented as the number of "Yes" elements out of the total number of scoring elements possible for each validation rating.

For findings of "No," the EQR team documented the requirements related to the findings and provided recommendations.

Table A-1 provides a percentage score, which correlates with the validation rating in reporting the results of the MCPs' PIPs that aligns with CMS Protocol 1.

Table A-1. Validation Rating Legend.

Validation Rating Scale	
Percentage of Activity Steps Met	**Validations Rating**
90% – 100%	High confidence in reported results
80% – 89.9%	Moderate confidence in reported results
70% – 79.9%	Low confidence in reported results
≤ 69.9%	No confidence in reported results

PIP Overall Score

The PIP overall score is based on the nine individual validation standard scores. The overall score is presented as the total number of "Yes" results out of the number of scoring elements possible for each of the nine individual validation standard scores.

Table A-2 provides a percentage score, which correlates with the overall score that aligns with CMS Protocol 1.

Table A-2. PIP Overall Score Legend.

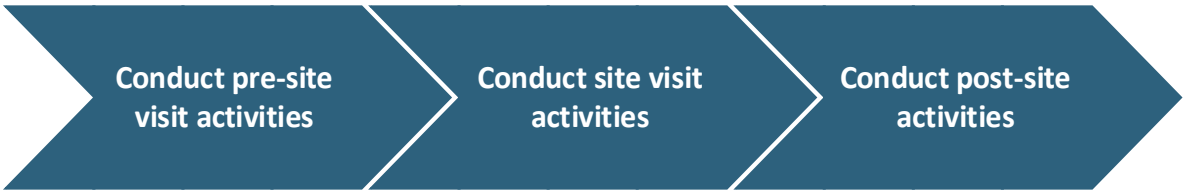
Percentage of Validation Ratings Met	Overall Score
90% – 100%	Met
80% – 89.9%	Partially Met
≤ 79.9%	Not Met

Appendix B: PMV Methodology

Technical Methods of Data Collection

Validating performance measures was conducted in July 2024 using the measurement years 2022 and 2023. The review followed the guidelines from *CMS EQR Protocol 2: Validation of Performance Measures.* According to 42 CFR §438.360, states have the option to utilize results from a private accreditation review to avoid duplication if the requirements are comparable to standards identified in the EQR protocols and 42 CFR §438.358. The performance measures identified by MHD for validation are NCQA HEDIS measures and are validated by an NCQA-certified HEDIS auditor which found (MCP's) submitted measures were prepared according to the HEDIS Technical Specifications and presented fairly, in all material respects, the organization's performance with respect to these specifications.

Comagine Health did not validate the measures but did conduct an analysis of the reported results in the FAR. The review consisted of the following three activities:



- **Conduct pre-site visit activities** – Comagine Health worked with MHD to identify performance measures for validation and determine process for review. MHD opted to utilize validation results from the NCQA HEDIS measures to avoid duplication.
- **Conduct site visit activities** – No site visits were conducted since validation of the identified performance measures was completed by NCQA-certified HEDIS compliance auditor. Comagine Health obtained copies of these reports and supporting data from the MCPs.
- **Conduct post-site visits activities** – The MCP's final audit report (FAR) reports and data was analyzed. Findings include the identification of measures that are strengths, compliant and opportunities for improvement. Results are reported to MHD and the MCPs.

Description of Data Obtained

The following data was obtained for the validation:

- FAR reports for the HEDIS Compliance Audit™
- Numerator and denominator data for each performance measure
- NCQA Quality Compass®*

*The source for certain health plan measure rates and benchmark (averages and percentiles) data ("the Data") is Quality Compass® 2023 and is used with the permission of NCQA. Any analysis, interpretation, or conclusion based on the Data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

The Data comprises audited performance rates and associated benchmarks for HEDIS measures and measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care.

NCQA makes no representations, warranties or endorsement about the quality of any organization or clinician that uses or reports performance measures or any data or rates calculated using HEDIS measures and specifications and NCQA has no liability to anyone who relies on such measures or specifications.

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HEDIS Compliance Audit Process

The MY2022 and MY2023 HEDIS compliance audit processes were conducted by an NCQA certified HEDIS auditor. The performance measures identified by MHD for validation are NCQA HEDIS measures and were validated according to the standards and methods described in the NCQA *HEDIS® Compliance Audit™ Standards, Policies and Procedures*. The audit had the following components:

- An overall assessment of the capability of information systems to capture and process the information required for reporting (also referred to as the ISCA)
- An evaluation of the processes that were used to prepare individual measures
- An assessment of the accuracy of rates reported

The review of information systems was performed to collect information that documents the MCP's efforts to ensure the accuracy and completeness of reported HEDIS rates. The findings from the information capabilities assessment formed the basis of a closer examination of the procedures used to develop the various HEDIS measures.

Data Aggregation and Analysis

The MCP's final audit statements and numerator and denominator data for each performance measure were analyzed. The NCQA Quality Compass® was used to identify national benchmarks.

Comagine Health employed both an Excel spreadsheet and an in-house Pearson's chi-square calculator to compile and score all measures, with data analysts on the EQR team interpreting the results.

In order to determine the significance of year-to-year results the Pearson's chi-squared test was used to evaluate the statistical significance for both increased and decreased results. The results of the test identified which changes were statistically significant and likely due to actions taken by the MCP or whether changes were due to normal variation.

Calculation of the Medicaid State Rate

The Medicaid State Rate for a given measure is calculated using the reported data from the four MCPs (HB, HSH, SMHK, UHC) for that measure. Each MCP reported numerator and denominator data for each measure. That data was aggregated to obtain the Medicaid State Rate.

Interpreting Percentages vs. Percentiles

The majority of the measure results in this report are expressed as percentages. The actual percentage shows a plan's specific performance on a measure. For example, if Plan A reports a Lead Screening in Children rate of 49%, that means that 49% of the eligible children enrolled in Plan A received the screening. Ideally, 100% of the eligible children should receive lead screening screenings. The actual rate indicates there is still a gap in care that can be improved.

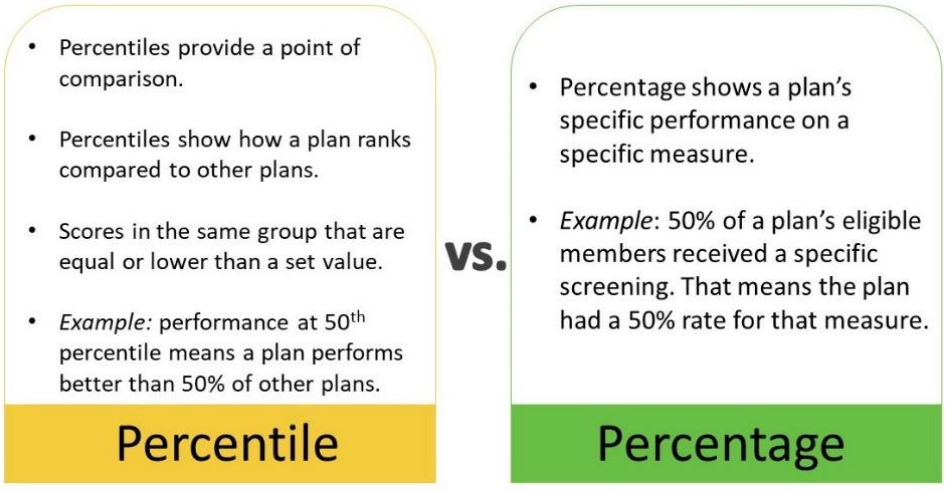
The national benchmarks included in this report are often displayed as percentiles. The percentile shows how Plan A ranks among all other plans reporting the Lead Screening in Children rates. For example:

- If a plan's Lead Screening in Children rate is at the national 50th percentile, it means that approximately 50% of the plans in the nation reported Lead Screening in Children rates that were equal to or below Plan A; approximately 50% of the plans in the nation had rates that were above.
- If Plan A is above the 75th percentile, that means that at most 25% of the plans in the nation reported rates above Plan A, and at least 75% of the plans reported rates below Plan A.

The national percentiles give a benchmark, or point of comparison, to assess how Plan A's performance compares to other plans. This is especially important in identifying high priority areas for quality improvement. For example, if Plan A performs below the 50th percentile, it can be concluded that there is considerable room for improvement given the number of similar plans that performed better than Plan A. However, if Plan A performs above the 75th percentile, it can be concluded that performance on that particular measure already exceeds the performance of most other plans and that improving the actual rate for that measure may not be the highest priority for this plan.

Figure B-1 shows the differences between percentiles and percentages in the context of this report.

Figure B-1. Percentile Vs. Percentage.



Scoring

Findings are categorized into a strength, meeting standards (compliant) or as an opportunity for improvement based on the national percentiles:

Scoring Legend

- **Strength** = measure rate above the 75th percentile
- **Compliant** = measure rate between the 75th and 50th percentile
- **Opportunity for improvement** = measure rate below the 50th percentile

Appendix C: Compliance with Standards Methodology

Comagine Health's review assesses activities for the previous calendar year and evaluates the standards set forth in 42 CFR Part 438, as well as those established in UHC's contract with MHD.

Technical Methods of Data Collection

The compliance review, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted in March 2024, using the review period of CY2023. The review followed the guidelines from *CMS EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*. The review consisted of the following five activities:

- **Establish compliance thresholds** – Comagine Health worked with MHD to develop the processes, scoring methods, tools and compliance thresholds for the selected standards to be reviewed.
- **Perform the preliminary review (desk review)** – Desk review includes assessment of MCP operations and practices, utilizing documentation submitted by the MCP and verification activities to confirm practices. The verification activity included a sample of providers from the MCP's provider network to confirm credentialing processes for qualified providers were implemented.
- **Conduct the MCP virtual site visit** – Interviews are held in order to collect additional information necessary to assess the MCP's compliance with federal and state standards and to clarify identified gaps and questions that arise from the review of the completed desk review. Participants in the interview sessions included MCP administrators, supervisors and other staff responsible for supporting care managers, staff responsible for improvement efforts and CM staff.
- **Compile and analyze findings** – The MCP's written documentation and responses to interview questions are used to score the performance on each element reviewed. Findings will include strengths, weakness/opportunities for improvement, recommendations and progress on prior EQRO recommendations from the previous year. Progress efforts will be ranked high, medium, low or not applicable.
- **Report results to the state** – Each report covers the specific review elements and corresponding sections of 42 CFR §438, MHD's contract with the MCP and other state regulations where applicable in compliance with 42 CFR §438.364.

Description of Data Obtained

Documents obtained and reviewed include a wide range of process-related materials depending on the area of focus, such as program descriptions, program evaluations, policies and procedures, meeting

minutes, desk manuals, staff training plans, data submissions, results and analysis of internal monitoring, narrative reflections on progress, reports, MCP internal tracking tools or other MCP records.

The verification activity documentation for EQR purposes includes the categories listed below, as appropriate:

- Denials – adverse benefit determinations/actions
- Appeals, including the denial portion of the file
- Grievances

Data Aggregation & Analysis

MCPs submitted documentation are stored and reviewed in databases, aligning with federal and applicable state regulations, as well as meeting contractual requirements with MHD. The databases are standardized data collection systems which store the following information:

- Requirements (standards under review)
- Documentation of findings from organizational document review
- Customized interview questions
- Rating of compliance by standard
- Rationale for compliance/non-compliance
- Recommendations for the organization
- Documentation from interviews with the organization

Scoring

Each standard has a specified number of scoring elements, which correlate with federal standards and MHD Contract requirements. Standard scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with a compliance rating that aligns with Protocol 3.

The following definitions are used to determine compliance for each scoring element:

Compliant:

- All policies, procedures and practices were aligned to meet the requirements, and
- Practices were implemented, and
- Monitoring was sufficient to ensure effectiveness.

Not compliant:

- The MCP met the requirements in practice but lacked written policies or procedures, or
- The organization had not finalized or implemented draft policies, or
- Monitoring had not been sufficient to ensure effectiveness of policies, procedures and practices.

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

Appendix D: NAV Methodology

Comagine Health performed the validation of network adequacy May – August 2024. The review was based on the third submission of the provider network data files as of July 1, due the last working day of July 2024. The review assessed activity requirements set forth in 42 CFR §438.68 and, if the state enrolls American Indians and Alaska Natives in the MCP, prepaid inpatient health plan or prepaid ambulatory health plan, 42 CFR §438. 14(b)(1). In addition, the review assessed each MCP provider network against the MHD's contract with the MCP, and the 2024 Provider Network Adequacy Standards.

Technical Methods of Data Collection

To ensure network adequacy, Comagine Health completed a comprehensive validation process for each MCP following the process outlined in *CMS Protocol 4: Validation of Network Adequacy*. This protocol involves six distinct activities, which are categorized into three phases:

- **Planning Phase**:
  - **Activity 1: Scope Definition** – During this initial step, Comagine Health and MHD agreed on the standards to be validated, specifically what is included and excluded in the scope and validation process.
  - **Activity 2: Data Source Identification** – Comagine Health confirmed that all relevant data sources needed for validation were identified and utilized, specifically enrollee and provider data.
- **Analysis Phase**:
  - **Activity 3: Information Systems Review** – This evaluation focuses on the information systems utilized to generate, capture and report accurate data for each network indicator, specifically reviewing the Information Systems Capability Assessment (ISCA) as well as any items not addressed in the ISCA. In addition, the MCP's membership, enrollment and provider information systems were reviewed as part of their HEDIS® Compliance Audits™.[17] Comagine Health reviewed the HEDIS compliance audit final audit reports for the membership, enrollment and provider systems. The HEDIS compliance audit includes an overall assessment of the capability of the MCP's information systems to capture and process the information required for reporting data. All standards were met with no adverse impacts identified.
  - **Activity 4: Data, Methods and Results Validation** – Comagine Health completed an assessment of the information, data and methods utilized by the MCP and MHD to produce the network adequacy results ensuring the accuracy and reliability of the findings.

[17] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

- **Reporting Phase**:
    - **Activity 5: Preliminary Findings Communication to MCPs** – Comagine Health provided initial findings to MHD and the MCP via a draft report and provided an opportunity for correcting omissions and errors.
    - **Activity 6: Submission of Final Findings** – Comagine Health submitted the final validation results and report to MHD and the MCP.

Description of Data Obtained

MHD provides managed care enrollment files to Quest Analytics on a quarterly basis. The MCP submits quarterly provider network files to MHD using the specified file formats. Accuracy of the data files is the responsibility of the MCP. MHD reviews the provider data submitted by the MCPs to ensure correct formatting as well as the appropriate provider types and counts of providers within each specialty prior to being transferred to the vendor, Quest Analytics for analysis, reporting and public posting. The MCP has the opportunity to correct data file errors in the next quarterly submission.

Quest Analytics receives the following data from MHD:

- Managed care enrollment files generated by MHD
- Provider data including facility and ancillary files generated by the MCP

A detailed description of the methodology, data sources, data files and exceptions criteria are included in the 2024 Provider Network Adequacy Standards.

In addition to the information provided by Quest Analytics, Comagine Health requested additional information from the MCP that was not listed in the 2024 Provider Network Adequacy Standards but was included in the MCP's contract with MHD.

Contract requirements and requested information from plans included:

1. List of contracts that support the inclusion of the Psychiatric Residential Treatment Facilities in their networks.
    a. Per section 2.5.9, item c. – Psychiatric Residential Treatment Facilities (hereinafter referred to as PRTFs) – The health plan shall include in the health plan provider network, both state- and privately-operated PRTFs that deliver psychiatric residential treatment services to youth with serious emotional disturbance when the youth cannot be treated in an alternative level of care.
2. Documentation supporting access to Indian Health Care Providers (IHCPs) for members.
    a. Per section 2.5.19 – American Indian/Alaskan Natives – The health plan shall ensure that American Indian/Alaskan Natives are permitted to receive care from IHCPs including Indian Health Services, Tribal 638, and Urban Indian provider.
    b. Policies related to this contract requirement.
    c. Member facing materials that demonstrate that American Indian/ Alaskan Natives are permitted to receive care from IHCPs.

Data Aggregation and Analysis

To begin the process, the MCP provides quarterly provider network data to MHD which then passes this information to Quest Analytics. MHD runs separate quarterly files for each MCP, containing statewide enrollment by ZIP code, as of the first day, of the first month, each quarter. Files are geocoded based on ZIP code only; addresses are not included in enrollment files. Geocoded member files created by MHD are provided to Quest Analytics.

MHD utilizes QES network adequacy analysis software to calculate the duration of travel time and physical distance between the addresses of members and the addresses of their nearest providers for all provider categories identified in the analysis. The results are stratified by MCP, as well as by county classification. Additional details of the methodology and data sources, including a description of Missouri counties, county classifications, provider types and specialties are provided in 2024 Provider Network Adequacy Standards.

For provider types that did not meet the access standard, exceptions will automatically be made by MHD for a county/provider type combination when **all** the following conditions are true:

1. There are one or fewer (two or fewer for PCP and OBGYN) “market providers” practicing in the county (i.e., the county contains insufficient providers of that type, regardless of their status as enrolled Medicaid providers).
2. No MCP scores 100%.
3. The MCP has the highest score among its competitors or is within five percentage points of the highest score attained by any MCP.

Market providers include all available providers based on taxonomy code.

Manual exceptions by MHD are considered in rare cases. If needed, written documentation of provider unwillingness to contract with the plan or demonstration that the database of market providers is not accurate may be requested. In either case, the indicator will be marked as “met via exception” for applicable county/provider type combinations.

Scoring

The validation score was derived by completing protocol worksheet 4.6. Assessment of MCP Network Adequacy Data, Methods and Results. This worksheet assists in evaluating and assessing the data and methods used to calculate results for each network adequacy indicator. Additionally, it guides us in generating a validation rating that reflects the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis and interpretation of the network adequacy indicator.

Calculate Validation Score

The responses to the questions in protocol 4 worksheet 4.6 were counted and entered in the Table D-1 below.

Table D-1. Calculation of Validation Score Legend.

Validation Score	
A – Total number of "Yes" responses	
B – Total number of scoring elements excluding elements scored as "NA"	
Score = (A / B) x 100	

Determine Validation Rating

The validation rating reflects the overall confidence that acceptable methodology was used during all phases of design, data collection, analysis and interpretation of the network adequacy indicators.

The table below shows the scoring legend including the validation score, which correlates with the validation rating in reporting the MCP validation ratings.

Table D-2. Determination Validation Ratings Legend.

Validation Score	Validation Rating
90% or greater	High confidence
51% to 89.9%	Moderate confidence
10% to 49.9%	Low confidence
Less than 10%	No confidence

Summary of Validation Findings

Summary of Network Adequacy Validation findings based on protocol worksheet 4.7, was completed for each MCP based on the results of the validation activities and review of the Quest Analytics reports.

The following table shows the validation rating that reflects the overall confidence that acceptable methodology was used during all phases of design, data collection, analysis and interpretation of the network adequacy indicators.

Table D-3. Summary of Validation Findings.

Network adequacy indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation rating
Provider Network Adequacy Indicators	Addressed	High confidence
	Missing	Moderate confidence
		Low confidence
		No confidence

Appendix E: Care Management Review Methodology

To ensure a MCP is in compliance with CM requirements in its contract with MHD, Comagine Health completed a comprehensive review of documents and clinical records provided by the MCP. The information gathered during the review helps assess the quality, access and timeliness of care provided to Medicaid beneficiaries within its CM program.

The review consisted of two components to assess compliance to CM requirements in its contract with MHD:

Compliance with Contractual Requirements (referred to in this report as Document Review) – an assessment of the MCP's compliance with CM contractual requirements, utilizing documentation submitted for selected criteria to be reviewed.

Clinical Records Review (referred to in this report as Clinical Review) – an assessment of the MCP's compliance with CM contractual requirements, utilizing a review of clinical records submitted for selected criteria to be reviewed.

The document review and clinical record review were conducted using review tools and reviewer guidelines developed by Comagine Health and MetaStar and approved by MHD.

Technical Methods of Data Collection

The CM review, a combined effort by clinical and nonclinical staff and subject matter experts, was conducted June through August 2024, using the review period of CY2023. The review followed the guidelines from *CMS EQR Protocol 9. Conducting Focus Studies of Health Care Quality*:

- **Select the study topic(s)** – MHD identified the topic and selected three focus areas for the study. Comagine Health worked with MHD to determine process for review.
- **Define the study question(s) and variables** – Comagine Health worked with MHD to identify the specific study questions, review standards and variables, as well as a plan to conduct the study. Review standards and study questions were identified for the three focus areas. Comagine Health and MetaStar developed review tools and reviewer guidelines.
- **Collect data** – Comagine Health and MetaStar used the approved review tools and guidelines to review each component. For the document review component, a desk review included an assessment of MCP operations and practices, utilizing documentation submitted by the MCP. Interviews are held to ask clarifying questions and collect additional information necessary to assess the MCP's compliance with contract requirements. For the clinical review component, random samples were generated for each focus area and the members were evaluated against contract requirements. The requirements for each focus area were grouped into indicators. Data was entered into an internal database.

- **Analyze, interpret and report study results** – Collected data was analyzed. Findings include the identification of indicators that are strengths, compliant and opportunities for improvement. Each report covers the specific review elements and corresponding sections of 42 CFR §438, MHD's contract with the MCP and other state regulations where applicable in compliance with 42 CFR §438.364. Results are reported to MHD and the MCPs.

Description of Data Obtained

Data obtained and evaluated consisted of documents and clinical records provided by the MCP are described below.

Document Review

Documents obtained and reviewed include a wide range of process-related materials depending on the area of focus such as program descriptions, program evaluations, policies and procedures, meeting minutes, desk manuals, staff training plans, data submissions, results and analysis of internal monitoring, narrative reflections on progress, reports, MCP internal tracking tools or other MCP records.

Clinical Review

Comagine Health submitted a randomly selected sample of 35 members enrolled in CM or DM, for each of the focus areas. An additional sample of 10 members who were eligible for CM, but did not enroll was evaluated for requirements related to the offering and opting out of CM.

Inclusion criteria for each focus area provided below:

- **Focus Area 1:** Multiple Comorbid Conditions (MCC)
    - All individuals who were diagnosed with at least two conditions and received at least one initial diagnosis during CY2023. For the list of applicable diagnoses, refer to MHD MCP Contract, section 2.12.1. Member CM; subsection e. General Eligibility and Assessment for CM.
    - No break in MCP enrollment for more than 45 days.
- **Focus Area 2:** Pregnancy/Obstetrics (PO)
    - All members with a pregnancy diagnosis in CY2023
    - No break in MCP enrollment for more than 45 days during the pregnancy
    - Member must not be enrolled in CM prior to pregnancy
    - Member still enrolled in MCP on delivery date or on December 31, 2023, if still pregnant
- **Focus Area 3:** Individuals in Foster Care, Receiving Foster Care or an Adoption Subsidy, or Other Out-of-Home Placement, referred to in this report as Foster Care (FC) **[SMHK only]**
    - All foster care enrollees during CY2023 (newly enrolled and those prior to CY2023) who have been enrolled in the MCP for a minimum of 60 days.
    - No break in MCP enrollment for more than 45 days

Member level documentation was obtained for the clinical record review including:

- Assessments
- Care plans
- Case notes

- Coordination and follow-up documentation
- Referrals
- Re-stratification criteria

Data Aggregation and Analysis

Documents and clinical records provided by the MCP were reviewed and the information and data aggregated and analyzed by the following methods.

Document Review

MCPs submitted documentation stored and reviewed in databases and using a CM review tool, aligning with federal and applicable state regulations, as well as meeting contractual requirements with MHD. The databases are standardized data collection systems which store the following information:

- Requirements (standards under review)
- Documentation of findings from organizational document review
- Customized interview questions
- Rating of compliance by standard pull
- Rationale for compliance/non-compliance
- Recommendations for the organization
- Documentation from interviews with the organization

Clinical Review

MCPs were given the option of submitting PDF copies of clinical records or allowing remote access via the MCP's electronic health record system. An internal database programmed with the selected criteria was utilized to aggregate and score indicator findings from the review.

Scoring

The document and clinical review components assessed activities for the previous calendar year and evaluated MCP's compliance with the CM standards set forth in its contract with MHD. The components were scored by the following methods.

Document Review

Each CM standard has a specified number of scoring elements, which correlate with MHD contract requirements. Scores are presented as the number of compliant elements out of the total number of scoring elements possible for each standard. This provides a percentage score, which correlates with a compliance rating that aligns with Protocol 9. A star rating is then assigned.

The following table shows the scoring legend for the document review.

Table E-1. CM Standard Scoring Legend.

Score	Compliance Rating	Stars
90% - 100%	Fully Met	★★★★★
80% - 89.9%	Substantially Met	★★★★
70% - 79.9%	Partially Met	★★★
60% - 69.9%	Minimally Met	★★
≤ 59.9%	Not Met	★

In addition, strengths, weaknesses/opportunities for improvement and recommendations are provided based on the review results. Strengths are defined as standards that scored at or above 90%. Weaknesses/opportunities for improvement are included for any standard that is below 90% and for any scoring element that was not met. Additional opportunities for improvement may be included for elements that are minimally compliant.

The following definitions are used to determine compliance for each scoring element.

Compliant (Fully Met):

- All policies, procedures and practices were aligned to meet the requirements
- Practices were implemented
- Monitoring was sufficient to ensure effectiveness

Not compliant (Not Met):

- The MCP met the requirements in practice but lacked written policies or procedures
- The organization had not finalized or implemented draft policies
- Monitoring had not been sufficient to ensure effectiveness of policies, procedures and practices

For findings of non-compliance, the EQR team documented the missing requirements related to the findings and provided recommendations.

Clinical Review

Each indicator has a specified number of “not met rationale,” which correlate with MHD contract requirements.

Findings are presented by focus area and categorized into strength, compliant and opportunity for improvement.

- Strength = indicator rate at or above 86%
- Compliant = indicator rate between 85.9% and 80%
- Opportunity for Improvement = indicator rate at or below 79.9%

Several of the indicator tables highlight the findings of non-compliance, or the “not met rationale.” Identifying the specific areas of non-compliance allows the plans to focus efforts on the most common areas of weakness in CM practices, which will have the greatest impact on improvement efforts. For indicator tables that include a count, this is a count of the reasons for non-compliance, meaning a lower count equals stronger CM practices.